

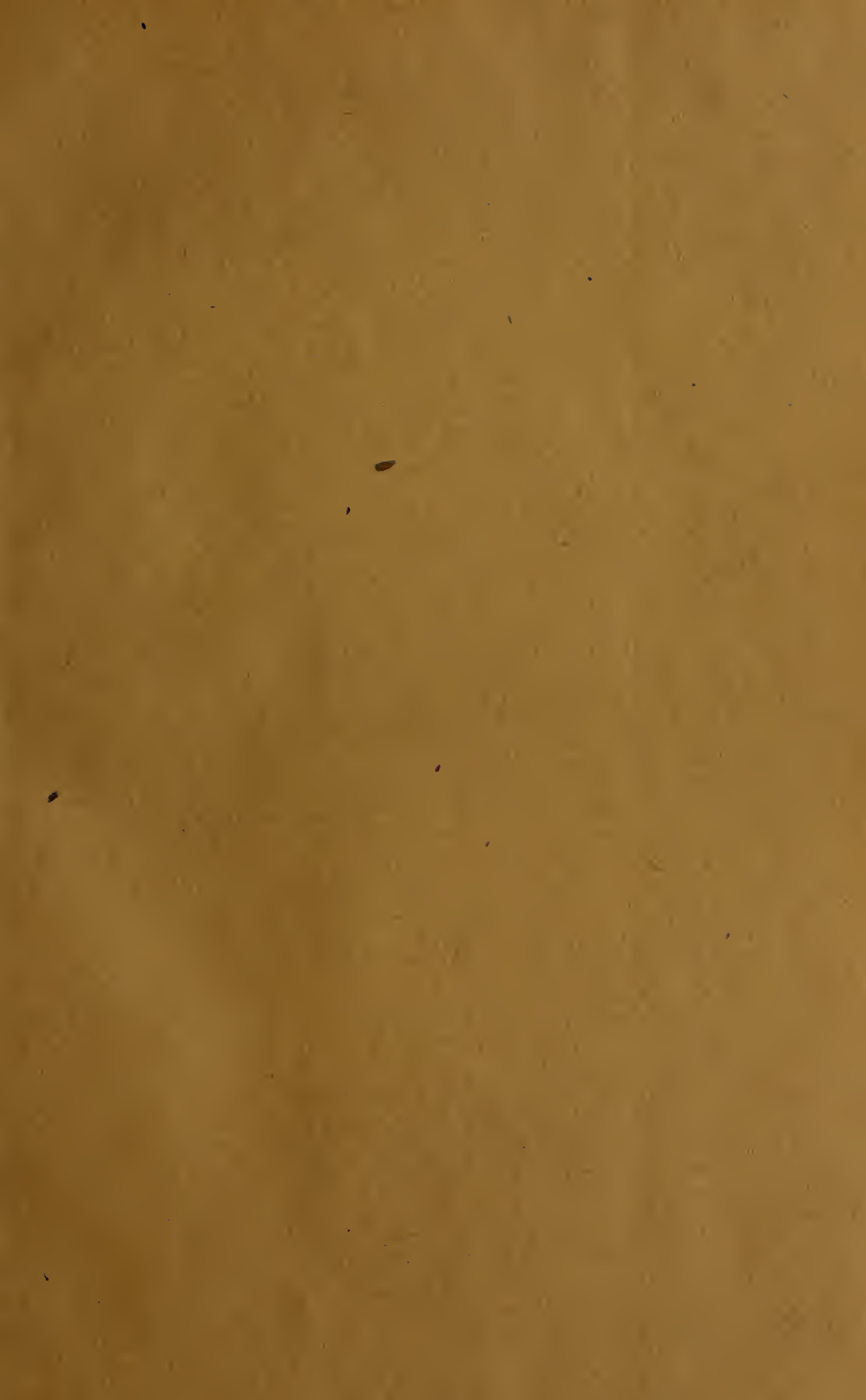
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# THE JOURNAL

OF

## THE KANSAS MEDICAL SOCIETY

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### **SUCCESS AND FAILURE IN MEDICAL ORGANIZATION.**

By FRANK G. CARMICHAEL, Goodland, Kan,

The selection of a subject for presentation at society meetings is by no means an easy task at all times, if one were to consider merely the scientific feature of these organizations, but while we may and do consider the scientific phase of medical organization, the paramount feature, questions of social, ethical, economic and legislative importance to the profession at large, merit a consideration and discussion they rarely receive on the program of county and district societies. It is not sufficient that members should make a thorough and exhaustive study of scientific subjects brought before the society, but should seek to present in addition such other data and personal observations as may prove of interest or benefit to its members, and to seek to present at each meeting something that may prove of value to the society as a whole or to some individual member. The impression that exists among many that a society meeting is merely an occasion for mutual back patting and interchange of verbal bouquets is entirely erroneous. A society meeting is where we congregate shorn of all pretense and pomposity, to contribute our mite, be it much or little, to the common fund of knowledge and to frankly discuss such questions as come before us, to champion our personal theories, prejudices and opinions, fortified by such collateral data as we may have access to; to give credit where credit is due; to criticise fearlessly where criticism is warranted, and to cheer, support and direct the profession in the paths that lead to highest achievement. At these meetings we present

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Read before the Western Kansas Medical Society at Oakley, Kansas, October 9, 1907,

ourselves, not as the physician whose theories and opinions are accepted by the laity without question or doubt, but as humble students seeking greater knowledge, divested of false value, judging and being judged by a body of our peers.

The value of an organization is determined by the ability, tact, energy and zeal of its members. Its maintainance and life are dependent upon the same factors.

In the brief review of the history of the Western Kansas Medical Society, which I shall present to you today, the frank criticisms I shall offer are not to be construed as reflecting upon any individual member, but apply to the society as a whole and are presented with a hope of correcting existing evils, avoiding future disappointments and contributing to the greatest welfare and utility of this society as a body. The Western Kansas Medical Society was organized and had its first meeting at Colby, November 15, 1905, its aim and objects being enunciated in Article 2, of the constitution, help, harmony and scientific advancement being primarily the objects in view. At this meeting there were present four active, practicing physicians who formed the organization, designed if possible to include the entire unorganized portion of the Eighth district. From this small nucleus, our organization has grown until it numbers among its members, representatives from every county in the Eighth district excepting Graham and Russell, and stands today with an enrollment of twenty members, energetic, capable and progressive representatives of the profession. With this membership let us glance back over the past two years and note what we have accomplished.

Our meetings have received only a fair attendance, the number of members in attendance at any meeting not exceeding seven.

Our programs have been filled at each meeting by voluntary contributions from members, the majority of whom have not appeared at the meeting, or appearing, have not prepared or presented their paper; the effect of this failure upon the part of those who have promised to contribute has been most detrimental to the interests of the society. I know of no better way to bring about an early demise of any society or organization than a failure on the part of those on its program to make good. A physician who puts himself to the inconvenience and sustains the financial loss incident to his attendance upon a medical meeting has a right to expect and demand something in return,

Let us examine into the abuse of this failure of interest. Our experience in the past has shown that at no time have we had an attendance exceeding 33 per cent. of our members. The natural conclusion is that the 66 per cent. who do not appear are either too busy or are not sufficiently interested in the welfare of the society to attend its meetings. If the former supposition were tenable the unfortunate members whose practices are so exacting as to grant them no time to attend medical meetings would be the object of our deepest sympathy but such is not the case. There is no member of this society whose time is so thoroughly taken up that he cannot spare a day every three months for his own advancement and that of the profession. Accidents may occur that may prevent a member from attending a meeting, but unforeseen conditions are not so frequent or coincident as to debar two-thirds of our members from attending every meeting.

We may, therefore, frankly ascribe the failure in attendance to lack of interest, disinclination or fear that our contemporary who perhaps is equally disinterested may filch one of our patients from us during our absence.

Why is it that so many of those who have promised papers have failed to materialize? Every member of the society is capable of producing a first class paper every three months. We recognize no incompetents. Every member is a graduate of an approved school, his practice is such that each year he has an opportunity to study many interesting or unusual cases that would prove of interest to his colleagues. Peculiar phases and anomalous conditions have come under his observation which might form the ground work of creditable papers. Every member has encountered cases that have induced him to a closer study of literature of that subject than his fellows. During the past two years there have been only six of the members of the society to contribute papers or less than one third of the membership. Five, or one-fourth of the membership, have promised papers that have never materialized, and nine, or nearly one-half, have ignored requests for papers or clinical reports.

So much for the evils that have existed in the past. How are we to correct them in the future? The future success of this society depends on the amount of attention and labor we give it. If we expect it to grow and thrive, to become so attractive that members will be glad to attend its sessions, every member should take a personal pride in its upbuilding and seek, not alone by his attend-



ance, but by his contributions, to further its interests and promote its future advancement. Nothing but concerted, harmonious efforts can accomplish the results this society is designed to achieve; these may be briefly summarized as, scientific advancement, interchange of ideas, community of interest, professional tolerance, mutual protection, questions of public health, professional ethics, and the discussion of such economic and legislative measures as may affect the profession as a whole.

A candid review of the causes operative in the production of poor attendance and poor programs in this society in the past cannot help but point the way toward a more satisfactory and efficient organization in the future.

It should not be a question of who will contribute papers or clinical material, wherein each member seeks to avoid a contribution and if importunities become so pressing that he is virtually forced into it, regards it a penance upon himself and an infliction upon the other members. Members should not require those who constitute the committee on program to write them innumerable letters soliciting material for program, but should promptly and definitely respond to such requests. This is not a question of ethics but of common courtesy.

Every member should have something to present at each meeting, and having volunteered a contribution, should see that his paper is presented. To assure this let each member send in his paper to the president or the secretary as soon as completed, and then if he is prevented from attending a meeting he will have atoned in a measure for his absence. Let discussions be free; if you have an opinion at variance with the essayist, voice it. We do not meet to have each member say at the conclusion of each paper, "Them's my sentiments, too," but for a review and comparison of opinion. We cannot all look at subjects from the same view-point, we cannot all accept as final and true the mandates of modern text-books or high-class medical journals. Courage is the keynote of modern scientific advancement. We require courage to promulgate a new theory, to advance a hypothesis, to make a diagnosis, to perform a surgical operation, no matter how slight, to present a paper on any subject or to criticise one that has been presented. None of us is expected to know it all, but we all have an equal right to our opinion, and it is essentially to air these that these meetings are inaugurated.

It is our desire to develop equally along all lines. The man who leans naturally to some particular branch in medicine, who makes a careful study of certain special morbid phenomenon is capable of contributing much to our store of knowledge from his observations, but his progress in one direction may have resulted in retrogression in another branch where we may benefit him.

The man who practices medicine from a financial standpoint alone differs from the Charletan only in that he possesses a medical diploma and the ethics of the profession protect him. His object is mere personal gain, his heart is not in his work and scientific advancement is a secondary consideration. To nearly every recent graduate thrust into the professional arena, down at heel and out at elbow, the promising lure of things to be achieved, of discoveries made, of therapeutic battles fought and won, leading to professional success and ultimate financial independence is a beacon light and incentive to their efforts, but in how many of these does the primary consideration become overshadowed and ultimately swallowed up by the latter, and yet you will note that there are very few even among the most noted of the profession who have acquired riches from their practice alone. The practice of medicine must be regarded as humanitarian above every other consideration, calling for constant study, application and interchange of ideas, yet the man who develops along the scientific line, who carries philanthropy beyond reasonable bounds, cheapens himself in the eyes of the laity, forfeits their confidence in a measure, and is slow in winning the preference enjoyed by his smugly complacent professional brother, who in addition to his professional skill has also acquired executive and financial ability.

The practice of professional ethics has resolved itself into a pure question of reciprocity; while some of the fundamental principles of the original code are still observed, many of the finer sentiments that went to constitute the original warp and woof of its fabric have long since ceased to be observed by the majority of the profession with the result that it has become threadbare and filled with holes through which, by plausible excuses and specious self-reasoning the constant violator may artfully dodge. The reason for this degeneracy may be found in the lack of confidence in and petty jealousies existing among the practitioners in rural districts. These conditions are as constant and as bitter as they are uncalled for, and as their influence is pernicious and detrimental to the best

interests of professional and social co-operation.

The deplorable tendency among many of our professional brethren to ignore the fundamental teachings of the code is witnessed almost daily and is one of the strongest evidences of the degradation of our profession to that level of commercialism which must be foreseen when the foundation of our dignity and integrity is attacked. To those who think that by withholding the courtesy that the code has extended to their brethren, that by showing contempt for the judgment, professional ability, or honor of their colleagues, they degrade them in the eyes of the public, to those who for purposes of financial gain or selfish and mistaken motives of professional advancement resort to innuendo, veiled sarcasm or open reviling of their colleagues we are in duty bound to extend that great charity of the strong toward the weak, the mature and healthy toward the mentally peurile and diseased and to seek by precept and example to demonstrate the folly of their course and its pernicious influence upon the profession as a whole.

It is one, and by no means the least, of the objects of a medical society, to seek by bringing its members together to create a more fraternal feeling and to eliminate as far as possible all discordant elements. The constant and steady advancement in the requirements of medical education, the almost universal requirement of academic courses in applicants for admission into all the institutions of the better class at the present time, while unquestionably tending toward a progressive excellence in the quality of their finished product, and while such requirements will curtail the number of poorly situated, poorly equipped and poorer taught institutions, organized and conducted for profit alone, that yearly pour out their quota of half prepared and thoroughly incompetent "physicians," a greater evil in the form of growth and multiplicity of osteopaths, vitopaths, magnetopaths and other nondescript cults, who, profiting by the honest efforts of our legitimate institutions to improve their standards, will flood the country with their charlatanism is to be met and combated. These quacks are unlimited in their scope of practice, are morally, and at the present time civilly, irresponsible.

Early legislative measures should be inaugurated for their suppression and for the protection of the public and profession at large. The time to do this is not when the evil is established, but if possible to forestall it by the requirement on the part of state



boards of such preliminary education and familiarity with the fundamental branches as anatomy, physiology, pathology and chemistry as are required by regular practitioners.

Such legislation can never be attained except through the vigorous concerted action of the entire medical fraternity, and as a preliminary measure every county and district society in the state should embody its views on this subject in the form of resolutions submitted to the state society, that concerted action may be taken to forestall these threatened evils.

The issue of the establishment of a standard fee for old line life insurance which was taken by this society in January last at which time a minimum fee of \$5.00 for all old line insurance was fixed, a copy of the resolutions printed in folder form and sent to all companies operating in our territory not paying the standard fee, has resulted in my locality at least, in securing the payment of this fee in all cases. In only one instance, that of the Banker's Life of Lincoln, was any quibbling indulged in. The above company, through the agency of their medical director, sought to make it clear that the hair splitting margins upon which their business was conducted, as well as the solemn duty they owed their patrons, absolutely prohibited the payment of such an extortionate price for medical examination, and intimated that the plutocratic tendencies of modern medical shylocks would result, if uncurbed, in the ultimate ruin and bankruptcy of all such beneficent (?) institutions as theirs, yet notwithstanding their penny wise policy the fee has been paid in our locality and I trust throughout the entire district.

This is certainly an encouraging beginning and shows what may be accomplished when we stand together loyally in a just cause. So much for the past and present. The future of this society is in our own hands. Regard it with indifference, make no special effort to attend its sessions, relegate the labor and trouble of it to your brother who perhaps has as little time to attend to it as yourself, complacently ignore requests for material and contributions and you will have a society that may exist a year or two in a perfunctory half-hearted way, but one that will eventually succumb to inanition. On the other hand, bestow upon it the care and time and study so worthy an enterprise deserves, endow it with the energy, zeal and resourcefulness so characteristic of the western doctor, and we will see it grow in usefulness, in scope and in importance until every member will experience a just pride in his society and his membership.

## THREE CASES OF TETANUS, ONE CASE OF HYDROPHOBIA, ONE CASE OF PRIAPISM.

By Dr. A. J. BEST, Centralia.

Mr. President and members of the Association: In presenting this paper it is not my purpose to go into elaborate details, or to present the subjects in all their scientific aspects. Nor to go into the minutiae of the many theories advanced.

My object is to give you in as few words as possible my experience and observation, in the cases the naming of which constitutes the title of my paper, and the discussion of which I hope will bring out the experience of many of the members present.

The first in order, Tetanus, is one of the infectious diseases caused by a specific organism the tetanus bacillus characterized by violent tonic spasms, marked by exacerbations and remissions.

It prevails as an idiopathic affection, or as the result of injury.

Trismus nasentium is probably caused by infection of the umbilical cord. In women after parturition it is generally fatal. When it occurs spontaneously it is called Idiopathic Tetanus. The most favorable form of wounds for the development of the diseases are lacerated and contused wounds, especially when nerves are involved. Injuries to hands or feet are more apt to permit of infection, than are wounds of other parts of the body. The disease may, however, follow surgical operations, extraction of teeth, vaccination, burns, frost bite, insignificant scratches, etc. But the most prolific of all sources of contamination is the soil, especially road dust. Rusty nails piercing the foot or hand are also very prolific causes.

It has been demonstrated that there is in connection with the disease a specific organism which can be isolated and cultivated. And animals can be made immune by inoculation with the blood of another which has had the disease.

(Diagnosis)—Osler says; well developed cases following trauma, could not be mistaken for any other disease. The spasms are not unlike those of strychnia poisoning, and in the celebrated Palmer murder trial, this was the plea of defense. The jaw muscles in strychnia poisoning, however, are never included early, if at all,

Read before the Kansas Medical Society of Kansas City, May 10, 1907,

and between the paroxysms there is no rigidity. The distribution of the spasm at the extremities, the peculiar position, the greater involvement of the hands, and the condition under which it occurs, are sufficient to make the diagnosis clear.

My first case was a boy of five years old, injured in the face by a fall on a rusty nail. The wound was dressed and healed nicely, but in about eight days he was brought to my office presenting all the symptoms of tetanus. He lived two days. I saw him at one o'clock on the second day, he was sitting on his mother's lap apparently not suffering much, at five o'clock he was dead.

My next case was that of a young man of eighteen who was injured in a runaway. The fourth finger of his right hand was torn off and infected by road dust. I first saw him on tenth day after the accident. The wound was sloughing and angry looking, he presented all the symptoms of lock jaw. The wound was redressed, thoroughly cleansed, and pure carbolic acid applied. He grew rapidly worse, the muscles rigid, and the least noise or sudden movement producing spasm. One night during a thunderstorm the convulsions were almost constant. I used Antitetanic serum Bromides, Chloral, and hypodermics of morphine, with only temporary relief. At last I bethought me of the bath tub, and this gave the first permanent relief. He would lie for hours in the warm water comparatively easy, and in the course of time he completely recovered.

The third case was seen in consultation. A girl of nine years was injured below the knee by a rusty nail. The wound was reopened, swabbed with pure carbolic acid. Anti tetanic serum administered, together with the warm bath, and careful nursing ended in complete recovery.

My treatment, if seen immediately after a suspicious injury, is to thoroughly cleanse the wound, and apply pure carbolic acid. If a nail has pierced a hand or foot, I wrap insorbent cotton around a probe dipped in carbolic acid and insert it three or four times into the wound. This usually destroys the germs and prevents infection. In combating the actual disease, I would depend on the serum, warm baths, complete isolation, only the doctor and nurse allowed in the room—and the use of such remedies as would be necessary to make the patient as comfortable as possible.

Two recoveries out of three cases is above the average.

### RABIES.

My next subject is rabies.



A boy of eight years old, the son of healthy parents, was bitten on the face by a cat that had been acting strangely for a few days. The wound was cauterized but in course of time I was called to see him, and on examination I found nothing wrong until he was offered some water, which caused spasm of the throat and choking. He lived about forty-eight hours after I saw him, dying from exhaustion.

Rabies is an acute infectious disease of animals, characterized by excitement, hyperaesthesia and deglutitionary spasms. More fatal when the wounds are about the hand or face, as when in other parts of the body, poisonous saliva is apt to be wiped off by the clothing.

The period of incubation is usually from four to eight weeks, but may be six months or a year or even longer. The wound through which infection takes place usually heals, but may become inflamed and irritated when the disease appears. As a rule only about ten to thirty per cent. of persons bitten by rabid animals become infected.

The spasms are very distressing and involve particularly the muscles of the neck and pharynx precipitated by the act of swallowing or taking liquids, hence the term, hydrophobia.

And here it might be well to mention the number of cases of pseudo rabies caused by worry and nervous excitement incident to bites from supposed rabid animals. These are probably the cases cured by the application of the mad stone, or Christian Science, the one as affective as the other.

Walker, in the Virginia Medical Monthly, says that the bite of a rabid animal will produce rabies in man or from animal to animal, but not hydrophobia from man to man. Senn, in his Principles of Surgery, in which all pathologists seem to agree, says the hope of recovery from true, well marked rabies is almost nil, death resulting in a few days. The treatment is essentially prophylactic. A ligature should be placed around the limb above the bite free scarifications and bleeding and the free use of carbolic acid. Pasteur treatment as a prophylaxis is by far the most important addition to our knowledge of prevention and treatment, since the first recognition of the disease and we hope to see greater results in the future.

#### PRIAPISM.

Our text books have very little to say on this subject, but we

find that it is a symptom in poisoning by certain drugs, also in genito urinary irritation. Phimosis, myelitis, hypertrophy of prostate and vesical calculus. A young man about thirty years of age, with no history of venereal disease. Had always been healthy but of a nervous temperament. Questioning elicited the fact that he had been somewhat excited—naturally—which had caused an erection which failed to subside. The next day he followed the plow, which kept up the irritation. I called the second day and found him in a condition that many old men would give dollars to be in if only it was natural. Prescribed bromides in large doses, cold pack, and cathartics. The next day no improvement, nor the next, nor the next. During the time I kept up the treatment with hot and cold water, ice bromides, chloral, morphine, etc; but without relief. I then prepared the bath tub, keeping his body immersed in warm water. This seemed to give some relief and in a few days he was better, eventually recovered, and has had excellent health ever since. Married and has several children.

My diagnosis in this case was that the long continued erection ruptured a blood vessel in the corpora cavernosa, causing clot, the irritation of which kept up the trouble

In conclusion I want to say a few words in praise of the wonderful animal serums, antidiphtheritic, antitetanic, pasteurs prophylactic for rabies, adrenalin, and thyroidectin for exophthalmic goitre. And let us hope that in the next decade more and wonderful discoveries will be made along kindred lines until the old time incurable diseases will be effectually controlled. When the devotion and untiring zeal of our noble profession has brought its certain reward. When the myths, and scisms, and pathies of ye olden time shall go down before the triumphs of modern medicine.

#### DISCUSSION.

Dr. Mitchell:—If there is any efficacy in the treatment of tetanus by the serum, it must be before the development of symptoms. If we hope to antidote the poison, we ought to make an effort to give the antidote before the development of toxic symptoms to administer the serum. If you do, the history of cases is that you had just as well inject it into a dog.

Dr. Masterson:—One word in regard to hydrophobia. We have some very well known men who say there is no such thing as hydrophobia. I saw one case that did not have a physician. I think every case of hydrophobia should be reported. I should like to hear the doctor's views on the treatment of hydrophobia.

Dr. —, Hutchinson:—Have any of the men present used carbolic acid for tetanus? I should like to say something about it. I believe it is very

highly recommended by an Italian physician. I heard a very interesting paper on the subject read in our society. I do not remember the exact views that he presented; or, what the solution was that he used, but he reported some cases in which he had used the serum that were fatal. He treated this case with carbolic acid.

Dr. Bolton:—I have had but one case in my practice I used the treatment of which the doctor speaks. My trouble was that I had never used it before and was afraid of it. I believe that if I had used more of it, I would have saved the boy's life. If I had it to do over, I should use more of it.

Dr. Shannon:—I have had no experience with tetanus in my private practice; but, while I was serving an internship at the hospital, we had eight cases one fourth of July. On those eight cases, we tried several different kinds of treatment. Carbolic acid was tried. I would take issue with the essayist on the strength of carbolic acid to be used. A strong solution of carbolic acid simply closes up the means of drainage. You want to use it sufficiently strong to kill germs, but not strong enough to close drainage.

Dr. Stemen:—In regard to the prophylaxis where you have patients who have been wounded by tramping on nails. The treatment should be to thoroughly cleanse the wound. I have had an extensive experience in the treatment of this class of cases. I cannot say that I have used a strong solution of carbolic acid. One thing that is important is the drainage. You must drain those wounds and keep them open. I was surgeon for the Pennsylvania railway Company at one time; and, we had a round house burn down; and, in a year's time, we had one hundred cases of tramping on nails. Not in one case did I have a single case of tetanus. If you think you have not gone to the bottom of the wound, take a piece of catgut; dip it in carbolic acid and then in water. Cleanse the wound and cleanse thoroughly, and I do not believe that you will fail in many cases. The doctor failed to show that he got to treat the case at the time of injury. Surgeons should not have tetanus in their cases. They should not have tetanus developed. I must disagree in regard to the serum. I think that about two years ago on the fourth of July, we had a number of cases of tetanus in the city and I think we treated all successfully but one. One died. Do not stop if you have a case of tetanus that develops symptoms. Get serum and use it. Do not say it is too late to use it. Use it, even if the tetanus has developed. There is a chance and the patient should have the opportunity to take advantage of it.

Dr. Sheldon:—This question of the use of serum has been discussed both ways. Both are perfectly right in that a prophylactic dose is better for the reason that the serum will neutralize the poison if found in the blood. The last speaker is right in saying that you should give the serum. This serum will not have any effect on the tissue that is already combined with the antitoxin, but the chemical material will neutralize the poison already formed. We should give a prophylactic dose and keep on giving.

Dr. Stillman:—One word about carbolic acid. You can disinfect these wounds just as well by the use of permanganate of potash as by the use of

carbolic acid. You will not have some going to the grave as a result of carbolic acid poisoning, if you do.

Dr. Masterson:—Might it not be a fact that the fire at the round house where they stepped on nails had killed the germs?

Dr. Stemen:—It might be a fact.

Dr. Best:—I have not much to say in reply. I wish to mention the time for using the serum. If a man had a case of diphtheria and would not use serum, you would think him a pretty bad case, wouldn't you? The only way that I know to practice medicine is to do the best we can in every case, and leave no stone unturned. In the first case, I used nothing—the patient died in two days. In the other cases, I used the serum freely, and they got well. The Pasteur treatment I know nothing about. Of course, you cannot tell what kind of preventative is good and what is not. Many cases do not develop rapidly; and, some do. That is the reason that the madstone has proven so good—it has been applied to cases that would have gotten well without treatment. I appreciate the doctor's remarks about drainage as well as the many other good points which this discussion has brought out.

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The second annual meeting of the association of Secretaries and Editors will be held at the Auditorium Hotel in Chicago June 1, 1908. Much good was accomplished at the Atlantic City meeting by comparison of methods used in the different states. It is hoped that Kansas will be represented at the Chicago meeting.



## **DYSMENNORRHOEA OF ADOLESCENCE.**

By DR. P. J. HENDRICKSON, Columbus, Kans.

Dysmennorrhoea of Adolescence is an anomaly of menstruation coming on during the period of adolescence, or growing up period. The word "Adolescence" comes from the Latin "Adolescens", which means to grow up, e. g. from a girl to a woman.

From a physiological standpoint this period is supposed to begin with the budding of the girl into womanhood, or, with the first menstrual epoch, and terminate with full physical development, which is placed at various ages in different countries, usually about the 22nd year.

Dysmennorrhoea of the Adolescent stage is not unlike dysmennorrhoea of the Post Adolescence stage. The word "Dysmennorrhoea" is made up of three Greek words, Dys. Men. and Rheo, which is taken to mean a painful monthly flow. Dysmennorrhoea is not a disease per. se.; it simply announces an abnormal condition, which may have a number of causes.

Before attempting a description or ethological classification of the various forms in which this great "Bete Noire" presents itself, it will be highly appropriate to gain a knowledge of and a correct idea of some physiological standard from which to judge the departure through which the system has passed from a normal condition.

Physiological action depends upon the existence of an anatomical structure, and in order to understand the nature of a function we must know something concerning the elements whose existence and nature makes the functions possible, hence, nothing short of a knowledge of the anatomy of the organs concerned in menstruation, together with their physiological action, can give any definite idea of a departure from a normal standard. The organs directly concerned in the function of menstruation are the uterus, fallopian tubes and ovaries.

### **ANATOMICAL STRUCTURE.**

Space will only admit of a brief anatomical outlining of the uterus, and its appendages. The uterus is a triangular shaped body with its apex downward. Losing sight of its triangular shape when viewed on section, this organ may well be likened in shape to

Read before the Cherokee County Medical Society.



an ordinary pear, and when unimpregnated is about the size of an ordinary pear. It is situated between the bladder and rectum, and is held in position by the broad, the round, the utero-sacral and utero-vesical ligaments.

Structure:—The uterus is made up of three distinct elements, viz: Peritoneum, unstripped muscular fibre and mucous membrane.

The peritoneum covers partially its external surface. The mucous membrane lines the cavity of the body and cervix, while the muscular fibre, by far the largest constituent forms the tissue lying between them. (The blood and nerve supply will be considered further on, under a separate heading.)

Coming next in point of continuity we have the Fallopian Tubes. The fallopian tubes are the tubes on each side of the uterus, running sinuously from its upper angle out towards the side of the pelvis. They lie enclosed in the upper free margin of the broad ligament and vary in length from 10 to 16 CM (3 to 4 inches). They are not of equal length, the right being frequently longer than the left. After leaving the superior angle of the uterus the course of the tube is straight for about  $2\frac{1}{2}$  CM (1 inch). It then curves outwards and forwards, and finally backwards and inwards, so that the whole tube has somewhat the shape of a shepherd's crook. Three parts come up for consideration: The isthmus, the ampulla and the pavillion or fimbriated end.

The isthmus is the straight narrow part of the tube which at its internal end opens into the uterine cavity, and has a lumen barely admitting a bristle. On transverse section the diameter of the whole thickness is about 2 to 3 M. M.

The Ampulla (jug like expansion) is the curved and thick part of the tube having an average diameter of about 6 to 8 M. M. with a lumen admitting the ordinary uterine sound.

Fimbriated end: The free fimbriated end of the fallopian tube sometimes called the pavillion, is expanded and funnel shaped, and it is provided with primary and secondary fimbriae, surrounding the opening of the tube to which they converge, one special fimbriae running to the ovary.

One section, the fallopian tube is seen to be made up of three layers from without inwards, viz: Peritoneal, longitudinal and circular unstripped muscular fibres (the latter being inner), and mucous membrane lined with ciliated columnar epithelium.

Connective tissues and elastic fibres lie between the peritoneal

and muscular layers. No glands exist in the mucuous membrane which is folded in a longitudinal direction, especially in the ampula

A remarkable anatomical fact is that the ciliated epithelium lining the fallopion tube and pavillon is continuous with the squamous epithelium of the peritoneum; and that further, there is direct continuity between the vagina, uterus, fallopion tubes and peritoneum—so that the peritoneal sac in the female is not closed as in the male.

Ovaries: The ovaries, two in number, lie one on each side of the uterus, pojecting markedly through the posterior layer of the broad ligament.

Form, Size and Relation: The ovary is a small oval shaped body about the size of a walnut, the weight of which varies from 60 to 135 grains. The average longitudinal diameter of the ovary is about  $1\frac{1}{2}$  inches; the transverse diameter (average) is about  $\frac{3}{4}$  inch; perpendicular diameter (average)  $\frac{3}{8}$  inch. The ovary has an anterior and a posterior border, and an upper and lower surface.

The anterior flattened and attached to the broad ligament. The anterior border is called the hilus, through which the blood vessels and nerves enter.

Relation: The long axis of the ovaries runs outward and forward, forming with the transverse axis of the uterus an angle open to the front. A part of each ovary, (about half), projects above the plane of the pelvic brim.—Husse & Schultz, on the other hand, figures the ovaries as having their long axis almost antero-posterior.

Ligaments of the Ovaries: In addition to the attachment which the broad ligaments give the ovaries, two important ligaments are described. The ovarian ligament, and the infundibulo pelvic ligament.

The ovarian ligament is about 3 C. M. in length (1 inch long), and extends from the inner end of the ovary to the corresponding upper angle of the uterus just below the uterine origin of the fallopion tubes. It is a longitudinal fold of the peritoneum into which the unstriped muscular fibre of the uterus is prolonged.

The infundibulo-pelvic ligament is about 2 C M long and runs from the outer end of the fallopion tube to the side of the pelvis. It is simply that part of the upper margin of the broad ligament unoccupied by the fallopion tube. The ovarian fimbria prevents the separation of the ovary and infundibulum tube.

Thus the ovary is kept in position by its attachment to the broad ligament, by the ovarian infundibulo-pelvic ligament. Its own

specific gravity has also a share in placing it as the ovary floats at a certain level.

**Structure of the Ovary:** The ovary has an epithelial covering differing from the Squamous Epithelium of the peritoneum in being made up of columnar cells with a dull lustre. It is continuous, however, with the peritoneal epithelium, the line of contact being marked by a whitish and elevated line. The epithelium covering the ovary is known as the germ epithelium. This distinctive term is of importance in connection with the development of the ova.

On section and microscopical examination the ovary is found to consist of connective tissue vessels, nerves, lymphatics, and some unstriated muscular fibre. These are enclosed in an epithelial covering already described.

The connective tissue is divided into a corticle and medullary layer, the former lying beneath the peritoneum, the latter being at and near the hilus. The medullary layer is very vascular and has some unstriated muscular fibres around the branches of the ovarian artery.

The Graafian follicles are scattered through the whole substance of the ovary. The following points should be noted: A. The younger and smaller Graafian follicles lie in the corticle layer. Their size is generally about 1-100 inch in diameter and they exist in immense numbers. According to careful estimates the ovary of a female infant may contain 40,000 to 70,000 such follicles. B. The larger follicles are much fewer in number and lie deeper in the ovary; size 1-30 to 1-100 inch in diameter. There are still larger follicles near the surface than the latter; these have advanced from the deeper layer.

**Structure of a Graafian Follicle:** This consists of,

- 1st. An envelope of connective tissue with capillary vessels.
- 2nd. The membrana granulosa, a layer of nucleated columnar epithelial cells forming the discus proligerus at one part.
- 3rd. Fluid. The ovum (size 1-100 to 1-130 in. diameter) lies in the discus proligerus. It has, first, an external envelope—zona pellucida; second, yolk protoplasm; third, germinal vesicle (diameter 1-700 in.) fourth, germinal spot (1-300 inch in diameter. Parovarium (organ of Rose Muller). If the broad ligament be held between the light and the observer's eye, this rudimentary structure will be seen enclosed in its folds in the space between the ovary and ampulla. It consists of closed tubules lined with ciliated epithelium, which



converge towards the ovary and are united by a longitudinal tube. Their pathological degeneration produces the cystic tumors, known as parovarian. Just what part the parovarium might play in the production of dysmenorrhoea is not well known to the writer.

Having given a partial and rather imperfect anatomical description of the organs directly concerned in the function of menstruation, our attention is now called to the most important element in the make up of the female generative apparatus, namely: blood and nerve supply. The ovarian artery of each side (corresponding to the spermatic of the male) is a branch of the abdominal aorta. Its relation when in the abdomen does not concern us here. In the pelvis it passes between the layers of the broad ligament, running tortuously towards the upper angle of the uterus. Near this it divides into two branches. The upper supplies the fundus uteri; the lower anastomoses at the side of the uterus with the uterine artery. The ovarian artery gives off—branches to the ampulla of the fallopian tube; branches to the isthmus, numerous branches to the ovary, and branches to the round ligament.

The uterine artery springs from the anterior division of the internal iliac and passes downward and inwards towards the cervix uteri; it then passes upwards between the layers of the broad ligament by the sides of the uterus in an exceedingly tortuous manner to anastomose with the ovarian. Branches pass from it into the substance of the uterus. These are known as the curling arteries of the uterus.

The vaginal arteries usually spring immediately from the anterior division of the internal iliac artery, but sometimes arise from the uterine or middle hemorrhoidal.

A special branch of the uterine artery to the cervix joins with its fellow at the isthmus to form the circular artery, and with those of the vaginal to form the asgos artery of the vagina. The vaginal arteries anastomosing freely with those of the opposite side. It will readily be seen why a ligature on the broad ligament in removing the uterus will control all hemorrhage.

**Venous Supply.** The venous supply of the pelvis is very abundant, and exists in the form of numerous plexuses freely communicating with one another. The veins are unsupplied with valves, which explains the profuse nature of a hemorrhage from wounds in the pelvic region.

The venous plexus lies extended to the muscular coat of the

bladder. The hemorrhoidal plexus lies below the mucous membrane of the lower part of the rectum. The veins of the labia correspond in distribution to the arteries. Those from the outermost parts drain into the pudic which opens into the common iliac vein. The veins from the glands and corpora clitoridis pass into the dorsal vein of the clitoris, which communicates with the vesical plexus.

The vaginal plexus—one outside the muscular coat and one in the submucous tissue—are most abundant at the lower part of the vagina, communicate with the hemorrhoidal and vesical plexuses, and open into the internal iliac vein.

The uterine plexus is very abundant, and ultimately opens into the ovarian veins, which pass on the right side to the inferior vena cava, on the left side to the left renal vein. The veins are small; they open into large sinuses in the middle layer of the coat, with which the capillary vessels communicate. The ovarian plexus, sometimes called the pampini form plexus, lies between the folds of the broad ligament and communicates with the uterine plexus. Some apply this term to all the veins in the broad ligament. The ovarian plexus opens into the inferior vena cava.

Beneath the peritoneum and between the layers of the broad ligaments are vast venous plexuses. A knowledge of these intricate, tortuous and anastomosing blood channels may sometimes reveal causal factor in the production of the so-called mechanical dysmenorrhoea by identifying a huge pelvic hematocele.

The vesical hemorrhoidal and vaginal plexuses, with the pudic veins, open into the internal iliac vein which opens into the inferior vena cava.

From the hemorrhoidal plexus, the superior vein passes into the portal system and thus we get a communication between the pelvis and portal venous system.

**Lymphatic Glands and Vessels.** The lymphatic glands and vessels are quite freely supplied to all the pelvic organs. In passing this part of the anatomy of the female generative organs it must not be inferred that the lymph gland and vessels are mere matters of anatomical detail, but are of the highest pathological and practical importance. The richness of lymphatic supply to vagina, cervix and uterus explains the extraordinary rapidity with which septic matter spreads through the body, and the extreme danger attending a slight lesion of the internal genital organs, when septic

matter is present and absorption has taken place. We may remark here, that septic matter will, of course, follow the lymphatic routes. A minute tracing of the lymphatic supply of the pelvic organs cannot be indulged in at this time, owing to the undesirable length of this paper.

**Nerve Supply.** The nerve supply of the pelvic organs come from the spinal and sympathetic.

The spinal gives branches to the levator and sphincter ani through the hemorrhoidal branch of the pudic, 4th and 5th sacral and coccygeal nerves.

**Sympathetic:** The hypogastric plexus, which lies between the common iliac arteries gives off branches which, reinforced by branches from the lumbar and sacral ganglia and sacral nerves, form the inferior hypogastric plexuses—on each side of the vagina. From these filaments proceed to the vagina, uterus, fallopian tubes and ovaries.

Now with this rough, disconnected and desultory anatomical description of the parts concerned in the function of menstruation, we will endeavor briefly to consider the physiological aspect of the subject.

Menstruation should be explained in this wise: An ovum ripens; this swelling of the Graafian follicle irritates the nerve termini in the ovary. The irritation is propagated to the central organs. Through reflexes, by vaso-motor processes, an arterial congestion of the internal female sexual organs is set up. This in turn increases the liquor folliculi so that the thick folliculi breaks and permits the ovum to escape-ovulation; and, second, the uterine mucosa becomes so hyperaemic that there occurs a bursting of the peripheral vessels, hemorrhage upon the surface of the uterine mucosa-menstruation results.

When these various physiological steps are taken in a normal way we have eumenorrhoea, or easy menstruation. Any marked departure from this standard would be denominated dysmenorrhoea.

All pathological conditions existing in the system of the female, when a direct or indirect connection can be traced—through anatomical construction with the generative apparatus, including muscular tissue, serous membranes, blood or nerve supply, may be designated as a causal factor in the production of anomalies of menstruation.

Dysmenorrhoea is a menstrual disorder sometimes called mens-



trual colic, intermenstrual pain, lumar-neuralgia.

Dysmenorrhoea, as we have said before, is not a disease of itself; it is simply pelvic pain associated with pelvic congestion and is a symptom common to numerous diseases.

Dysmenorrhoea may be local or pelvic, general or constitutional, or reflex in origin.

Thus we find dysmenorrhoea in neurotic and hysterical women, in anaemic, undernourished and constipated women, in chronic malarial conditions, in stenosis of the os or uterine canal, in imperfect development of the uterus (small body and large cervix) in flexions and malposition of the uterus, in uterine and pelvic tumors (fibroids) and circulatory disturbances (heart disease).

Dysmenorrhoea of the purely neuralgic form is found in cases of autointoxication from intestinal putrefaction, certain subjects of a toxic nature seem to have a predilection for irritating certain nerve tracts, a fact which is frequently overlooked in the therapeutical management of all forms of neuralgia.

Dysmenorrhoea, therefore, is produced in various ways by various pathological conditions, and the therapeutical management of a case of dysmnorrhoea must be the result of a careful study and analysis of the underlying pathological conditions.

Dysmenorrhoea is usually divided into certain forms. In view of the foregoing facts in regard to its causes we fail to see how a classification can be warranted.

It is claimed by some that dysmenorrhoea is associated with certain diathesis, such as the gouty and rheumatic.

2nd. Spasmodic, due evidently to a neurosis. 3rd. Membranous dysmenorrhoea; 4th. Dysmenorrhoea associated with inflammatory conditions of the ovary, peritoneum or cellular tissue; 5th. Ovarian Dysmenorrhoea. Permitting us again to call attention to the fact that dysmenorrhoea is not a disease per se. we are inclined to look upon the above classification as unnecessary and unscientific.

Losing sight of names and classifications of diseases, we are induced to search for conditions and causes, the removal of which constitutes rational therapeutics.

Treatment: The treatment of dysmenorrhoea is both palliative and curative or iterim. Among the palliative measures may be enumerated, 1. Rest in bed, hot applications, prolonged hot sitz baths, hot drinks, hot bags to the lumbar spine, and the exhibition of such nerve sedatives and antispasmodics as will remove the agony of the patient and secure rest, which usually follows the estab-

ishment of the flow.

A very useful recipe in my hands consists of oz. III of Hayden-Viburnum compound. with oz. I of Papine. A teaspoonful in hot water every half hour until 4 or 5 doses have been taken when the intervals may be extended if relief is promising. Hot pediluvium may synergise this prescription if the extremities are cold.

If the patient is a blonde and exhibiting great emotional excitement, disposed to cry easily, evidencing marked sympathetic disturbance, I have found the Tr. of Pulsatilla in one drop to two drop doses every half hour to act admirably. I have recently found the alkaloid of conium maculatum gr 1-67 administered in hot water every half hour for 4 or 5 doses to give entire satisfaction in dysmenorrhoea, also Gellsemin the concentration of Gellsemin in 1-10 gr. doses to have a remarkably soothing effect in these cases, especially if pushed to its physiological effect on the eye lids. Extreme cases, however, will be met with wherein we feel justified in resorting to more heroic measures—such as hypodermic medication and the administration of chloroform or ether, but we are inclined to think such heroic treatment only called for in a small per cent. of cases.

The indiscriminate use of morphine and whiskey for the relief of patients suffering from dysmenorrhoea (especially those of the neurotic type), and allowing the patient to know the nature of the remedy used, has caused the downfall of many women and added new recruits to that vast army of morphine habitues and dipsomaniacs, hence, the necessity for a faithful effort to give permanent relief in all such cases.

The curative treatment consists in searching for the cause and removing it if possible. Intermenstrual pain and ilio lumbar neuralgia requires the most careful search for their origin. One of the most common conditions met with in the female is what may be called menstrual lumbago, a condition not unlike lumbago in subjects wherein the menstrual element is not to be considered. This condition calls for very similar treatment to the independent lumbago. We find the same conditions as revealed by an analysis of the urine with reference to retention of uric acid and the uric acid diathesis. Dysmenorrhoea occurring in girls of a rheumatic habit should have in addition to such palliative measures as seem indicated for immediate relief, a thorough inter-menstrual treatment with due regard to any existing rheumatic inflammation or irritation, in fibrous and nervous structures of the uterus and ovaries,



conditions frequently established by injudicious exposure of the feet and legs to cold and wet even before the age for commencing menstruation, in which case the organs acquire both increased density and sensitiveness. Hence, the increase of vascular fullness accompanying the beginning of each menstrual period is productive of pain more or less intense.

A suppository containing 2 grammes of chloral hydrate with 5 or 6 centigrammes of extract of belladonna introduced into either the vagina or rectum will quickly modify these painful paroxysms. This local treatment is mentioned as a substitute and adjunct to other palliative measures. Among the inter menstrual remedies recommended by the various authorities on the subject and those found most useful by the writer, may be mentioned Ex. Helonias, Ex. Star Grass  $\frac{1}{2}$  gr. Ex. Vib. Prun. gr. I Ex Squaw Vine gr.  $\frac{1}{2}$  Caulophyllin gr.  $\frac{1}{4}$  Vib. Op. gr. I. The well known formula (Dio. Viburria Elix.) contains about all the uterine tonics that are of any special benefit as an intermenstrual treatment, for routine prescribing. Special investigation of the cause should constitute the first step, and a careful selection of the treatment which should include hydro and electrotherapy.

## A FEW PHASES OF LEUCOCYTIC ACTIVITY.

By B. BELLE LITTLE, M. S., M. D., Manhattan, Kansas.

Certain forms of leucocytes are, as we know, found in a more or less constant percentage in healthy blood of the adult, while certain other forms are never seen in the circulating blood stream in health, appearing only during some pathological condition of the organism. Percentages of the several forms found constantly in health vary somewhat according to the reports of investigators, but the following percentage closely approximate accepted averages:

Polymorpho-nuclear leucocytes.....	67-75 per cent.
Small mononuclear lymphocytes .....	20-30 per cent.
Large lymphocytes and transitoral forms.....	4-8 per cent.
Eosinophiles.....	0.5-5 per cent.
Basophiles as high as.....	0.5 per cent.

Thus it will be seen that in adult life the polynuclear leucocyte predominate greatly over the other forms. In infancy, however, the small lymphocytes are greatly in excess. During adolescence and continuing through adult life, there is a decrease in the percentage of small lymphocytes and a concomitant increase in the polynuclear leucocytic percentage. Regardless of percentage, the following forms have been described as appearing in the blood stream only during pathological states: Myelocytes, Mast cells, Mononuclear neutrophiles, false lymphocytes and "stimulation forms" (Reizungs formen).

The nuclei, of the polymorphar nuclear leucocytes, are, as the name indicates, many shaped; the various shapes being believed to be indicative of the amoeboid activity of the cell. The protoplasm is studded with very fine granule quite irregular in shape, these granules being more closely packed at the periphery of the cell and the protoplasm becoming more hyaline in character immediately surrounding the nucleus.

The small lymphocytes contain a single round nucleus, relatively large, and almost completely filling the cell body; a very narrow zone of non-granular protoplasm may be detected between the nucleus and the cell wall. The large lymphocytes contain a nucleus round or ovoid in shape, and somewhat eccentrically placed. The protoplasm is non-granular and distinctly visible between the nucleus

and the cell outline.

The eosinophile is characterized by its granular protoplasm, the granules being very coarse and almost uniformly spherical in shape. They are very loosely placed in the cell, with a tendency to obscure the nucleus. The granules frequently become quite detached from the cell and appear as a cloud about it. The nucleus is horse-shoe or kidney-shaped.

The basophile is a variety found in health with great rarity. Its significance is little understood. Its nucleus is polymorphous and its protoplasm finely granular. It is distinguished from other forms which it may resemble by certain staining affinities.

The typical myelocyte somewhat closely resembles the large lymphocyte, but is at once distinguished by its non-granular protoplasm.

The mast cell shows wide range in size, being found as small as 7u and as large as 22u in diameter. Its protoplasm is almost indefinable, the nucleus structureless, the outline of the nucleus being so indefinite as to appear almost blended with the surrounding protoplasm. The great diversity in size and shape of the protoplasmic granules, not only in different cells, but in the same cell, is highly characteristic of the mast cell.

Three forms of leucocytes, the mononuclear neutrophiles, the false lymphocytes, and "stimulation forms", have been recently described as occurring in certain pathological conditions, but their classification and significance remain undetermined.

While progressive research will undoubtedly show that our present knowledge of the forms and characteristics of the white blood cells is grossly incomplete, we, even now, in the incomplete development of the subject have at our command almost limitless source of aid to the practitioner. Let us look at the subject from the standpoint of the diagnostician.

Normally human blood contains from 7,000 to 10,000 leucocytes to the cu. m. m. An increase above this number in the peripheral blood, the increase involving principally the polymorphous nuclear variety, constitutes a leucocytosis. Lymphocytosis, eosinophilia and basophilia are terms applied respectively to an increase above the normal standard in the large and small mononuclear lymphocytes, the eosinophiles and basophiles; common usage limiting the term leucocytosis to an increase in the polynuclear form.

Leucocytosis occurs in definite physiological conditions, as well

as during certain pathological processes. Physiologically it is limited to leucocytosis of the new born, digestion leucocytosis, mechanical and thermal influences, pregnancy and parturition, and preagonal leucocytosis. Physiologically the increase is slight.

Pathologically leucocytosis occurs in a great variety of inflammatory and infectious processes, after hemorrhage, in the presence of malignant disease, and as the result of the ingestion or inhalation of toxins, for example, ptomaines and coal gas.

The occurrence of leucocytosis so generally in pathological processes would lead one to consider it of doubtful utility in differential diagnosis, but further research discloses its value.

I have endeavored to collect from various sources those pathological processes in which a differential count of the various forms of leucocytes would be of material assistance to the physician in diagnoses and an illustrative group I wish to present to you.

Leucocytosis cannot be said to occur in certain types of disease to the exclusion of other types. Thus, unless intoxication is intense and the patients' resistive powers are feeble (factors which may mar the blood picture in any infection) leucocytosis occurs in such infectious processes as small pox, scarlet fever, diphtheria and pneumonia, while it is absent in measles, influenza, uncomplicated tuberculosis and typhoid fever,—and yet all are infections of bacterial origin. What determines this seemingly selective influence is at present obscure.

In considering tuberculosis lesions in various parts of the body, observation of the white cells may be of considerable assistance to the diagnostician. Da Costa says:

“In cases of unmixed infection these cells (that is the polynuclear variety) do not rise above the normal limits of health, but the moment the tubercal lesion becomes complicated by a secondary infectious process, the accident is heralded by a prompt increase in their number. For example, in a simple tuberculous adenitis the count is normal, but should the glands ulcerate, fistulate and become septic a leucocytosis at once develops. As a rule the qualitative changes are inconspicuous, although in some forms of the disease there is a tendency toward lymphocytosis.” \* \* \* \* “In pulmonary tuberculosis leucocytosis may be symptomatic of cavities, rapidly spreading broncho-pneumonia and of acute pleurisy.”

In tuberculosis of the bones and joints the reports of investigators agree that a high leucocytosis, especially if sudden and rapid in onset, indicates either abscess formation or that its formation is pending, although a moderate and slowly developing leucocytosis



is not incompatible with active extension of an uncomplicated tubercular process.

Low counts in pleural, pericardial and peritoneal effusions are very suggestive of a purely tubercular origin. The count may be high in tubercular peritonitis, owing to co-existing inflammatory processes, which are nearly always present. Tuberculosis of the genito-urinary tract is most frequently accompanied by a leucocytosis, because these cases are rarely uncomplicated.

Observations of the leucocytes throws some dependable light upon the diagnosis of malaria.

But, you may say, observation of the leucocytes is unnecessary when proof is furnished by the presence of the plasmodium in the red cells. If your patient has been taking quinine, search of the red cells may prove futile. If the malarial parasite is present in the blood, at some time during its life cycle malarial pigment may be demonstrated in the polynuclear and mono-nuclear leucocytes. In malarial fever there is a decrease in the number of polynuclear leucocytes with a relative increase in the lymphocytes, involving principally the larger form.

Typhoid fever discloses the same leucocytic picture, excepting where in malaria the large mononuclear forms are increased, in typhoid the small lymphocytes show increased numbers.

Malignant endocarditis often gives rise to constitutional symptoms so profound as to cloud the diagnosis, malarial and typhoid fevers being the pathological conditions most frequently confused with it. Leucocytosis (increase in the polymorphous variety) occurs in malignant endocarditis and is absent in malarial and typhoid fevers.

In obscure cases of pneumonia, leucocytosis excludes typhoid and malaria fevers and influenza, conditions most frequently confused with it.

The foregoing conditions are sufficient to illustrate the value, to the diagnostician, of differential blood counts. This field for observation and research is almost limitless.

A knowledge of the behavior of leucocytes in pathological states, becomes of great interest and importance when we consider the function of these elements and the conditions under which these functions are most actively performed.

The phagocytic action of the leucocytes has long been considered their predominant function. Modern research confirms this view of the older investigators, but at the same time it presents

proof of a more elaborate method of protecting the body from the deleterious influences of invasion by organisms, than by the mere mechanical inclusion of foreign bodies by leucocytic amboïd activity.

Results of research by Wright & Douglas of London, are unprecedented and lead one to believe that we are only on the border line in knowledge of the manner in which the protective functions of the human economy are executed.

The leucocytes have been brought into relation with antitoxic immunity and the formation of antitoxin, with bactericidal and bacteriolytic effects, and in an indirect way with agglutinins and opsonins.

Regarding the relation of the leucocytes to anti-toxic immunity and the formation of anti-toxin it is my purpose only to suggest the trend of opinion, which is quite concisely done in the following paragraph extracted from a recent work by Rickets on "Infection, Immunity and Serum Therapy."

"In experimental tetanus exudates which are rich in leucocytes contain more toxin than does a similar quantity of blood. That is to say, the leucocytes have the power of absorbing toxins and it is held that the natural immunity of the animal depends on the degree to which this power is present. The immunity of the chicken to tetanus depends not on non-susceptible nerve-cells, but upon the absorbing power of the leucocytes for the toxin. Not only do leucocytes absorb toxins, but it is held that they also are the producers of antitoxins. As compared with the "side chain theory" it is a peculiarity of the view of Metchnikoff that antitoxin does not represent a constituent of the tissue cells, but rather the toxin itself which has been altered by leucocytic activity in a manner as yet obscure. In passive antitoxic immunity the idea of chemical union between toxin and antitoxin does not meet with general acceptance among the upholders of the phagocytic theory. It is sometimes said that antitoxins are efficacious from the fact that they stimulate phagocytosis (absorption) of the toxin, the latter then suffering disintegration in the leucocytes."

Thus we may accept any one of several theories regarding the function of leucocytes in immunity as follows:

1. The leucocytes absorb the toxins and, if you please, disintegrate them after absorption.
2. The leucocytes elaborate antitoxins.
3. The leucocytes alter the toxins chemically, thereby producing antitoxins.

The bactericidal and bacterolytic functions of the leucocytes have been established beyond peradventure, but recent disclosures



have proven them to be more complex processes than heretofore believed. According to the researches of Wright & Douglas active leucocytic ingestion of organisms depends much on certain elements contained in the blood serum, namely, agglutinins, but more especially, opsonins.

Theoretically agglutinins render the organisms less motile, so they are more readily captured by the leucocytes.

Opsonins appear to be more intimately associated with the leucocytic ingestion of organisms.

If, in experimentation, the leucocytes be washed free of all serum, their ingestion of bacteria is quite limited. Figuratively speaking, they lose their appetite; some nibble here and there, others linger around in a half hearted way, while still others in true ameboid fashion put out pseudo-legs and walk away. But if the bacteria are treated with blood serum before being offered to the leucocytes, leucocytic activity is marked. They speedily gorge themselves to their fullest capacity.

A discussion of the pathological condition causing an increase or a decrease of the opsonic index and the therapeutic measures for bringing about its normal standard is beyond the scope of my subject.

## MINOR SURGERY.

By R. C. LOWDERMILK.

In considering this subject no effort will be made to describe any particular operation, but rather devote myself to a general consideration of the technique of such work with special reference to such methods as I have personally found useful.

By the term Minor Surgery, we understand those operations which are not of such a nature as to endanger either life or the general functions of the parts involved. This constitutes the greater part of the surgical work done by the general practitioner and consequently has greater interest for him than does major work, most of which, because of our lack of experience as well as proper facilities, is referred to others. For the proper performance of this work it is essential to have a fairly complete equipment. While most minor work may be done with such instruments as are contained in a pocket case it is desirable to have an assortment of instruments the number of which will be limited only by the expense. Some kind of table or chair is found in nearly every office as are also douch bags and a Kelley pad. A sterilizer should be in every office, but unfortunately is not. I have known men to enjoy large practices without any means of sterilizing their instruments except washing them in some antiseptic solution. After instruments are sterilized and placed in the case a small vessel filled with formalin may be placed with them; the gas from this will fill the case without any injury to the instruments and will act as a constant disinfectant. A few glass jars, such as cigars are packed in, make convenient containers for gauze, cotton, and other dressing materials. To secure a constant supply of sterilized water I had a tinner make a container from sheet copper having a capacity of about six gallons and provided with a closely fitting cover and a faucet. This is kept filled with sterilized water and by attaching a tube to the faucet it becomes an irrigator. The addition of some boiling water may be made if desired, which raises the temperature to any desired point.

For doing work away from the office it is well to have a Gerster bag. This is a bag of the log cabin style, about eighteen inches long, fitted with loops inside for holding bottles and instruments, and provided with two pans about two inches deep, nested,

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and just fitting the bottom of the bag outside. These are held in place by straps, occupy no room, and serve both for sterilizing and as instrument trays.

The different pharmaceutical houses offer a large number of preparations for use in dressing wounds, and the number is being constantly increased; I shall mention only a few which meet every requirement. For dry dressing nothing is equal to iodoform; the only objection being its disagreeable odor, which may be modified by the addition of cumarin in the proportion of one per cent. Should an odorless dressing be preferred glutol will meet all requirements; this is prepared by passing formaldehyde gas into a solution of gelatin, drying and powdering. It is perfectly odorless and in contact with living tissues slowly liberate small quantities of formaldehyde gas which exert a constant disinfectant effect. One of the most generally useful dressings is Campho-phenique used either pure or with olive oil. It may be easily and cheaply made by adding four parts of pure glacial carbolic acid, liquified by heat, to six parts of gum camphor. In a few hours they will liquify when the resulting solution is strained through cotton and is ready for use. In making it care must be taken to use the pure crystals of carbolic acid as the addition of the least quantity of water will spoil it. It will not mix with water or glycerine, but may be diluted with olive oil. While it contains forty per cent of phenol in addition to the camphor, which is also an excellent antiseptic, it is absolutely non-irritant. Only when applied to large raw surfaces such as extensive burns, have I ever seen any bad results from absorption of the phenol. Another useful application for use on burns and to promote granulation is a ten per cent. solution of balsam peru in castor oil.

Some kind of anaesthetic is often needed, and to avoid the danger of using a general anaesthetic, several methods of local anaesthesia have been devised. The best for general use is the Schleich infiltration method, as it is effective and absolutely safe. The solution is made by dissolving two grains of cocaine, one-half grain of morphine and four grains of common salt in four ounces of sterilized water. This is injected into the skin and then into the deeper tissues and causes complete anaesthesia, which lasts, about half an hour. Another method which is now being exploited is the morphine-hyoscine injection, in my experience it is fairly satisfactory in some cases and an utter failure in others. It is still an experiment and may be so improved as to make it a useful method in the future.

Before doing any operation, no matter how trivial, both the operator's hands and the field of operation must be thoroughly cleansed, since the danger of sepsis is as great in a small operation as in a large one. If the field is covered with hair it should always be shaved. For cleansing the parts a liquid soap will be found convenient and effective, and may be made by adding two parts of green soap to one part of alcohol. This may be scented with oil of rosemary if desired. After thoroughly scrubbing the field of operation with a stiff brush it is flushed with a solution of bi-chloride of mercury and the surrounding parts protected with towels saturated with the same solution. Since it is seldom necessary to bury sutures in this work silk is usually the only suture material needed. For some work an ordinary curved perinal needle will be found very convenient for suturing; the sutures can be placed more rapidly, no needle holder is needed and the needle does not have to be threaded.

The wound is usually dressed with gauze, cotton, and a roller bandage and it may not be amiss to say that cotton should never be placed in contact with the flesh because of the difficulty of removing it at the subsequent dressing. In many cases, such as scalp wounds, a very efficient and inconspicuous dressing may be made of cotton and collodion. In using this care should be used to have only enough cotton to give strength to the collodion, if too much is used the dressing is stiff and liable to come off. This is applicable only to clean wounds where neither suppuration nor hemorrhage is expected. If the wound is oozing, or if some suppuration is expected, a very neat dressing may be made by using a small piece of cotton between two pieces of gauze, the edges of which are secured to the skin by collodion. This avoids sealing the wound and will take care of a small amount of discharge.

In wounds of movable parts, such as the hand, the use of splint will make the patient more comfortable and also promote the healing process.

Minor surgery is usually emergency work, and is done by the local physician. Being visible, it appeals to the patient and his friends to an extent that medical diagnosis and treatment cannot. The amputation of a finger, if done neatly, does more to enhance the reputation of the physician than does the correct diagnosis and proper treatment of a case of typhoid. For this reason, if for no other, it will pay the general practitioner to give more attention to this work.



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CHAS. S. HUFFMAN, . . . . . EDITOR

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**Meeting of State Society.**—The Kansas Medical Society will meet at Iola May 6, 7, 8, 1908.

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Dues for the year 1908 should be paid at once, so that all members may receive their 1908 membership card.

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At the meeting of the Council of the Kansas Medical Society, December 27, 1907, Dr. E. J. Lutz presented the following resolution:

Resolved, That the council of the Kansas Medical Society commend the action of the president in the stand he has taken, by issuing an order, giving the medical corps of the navy actual control, where it has actual responsibility.

This resolution was unanimously adopted and the secretary was directed to send a copy to Surgeon General Rixey of the Navy.

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An article published in the Chicago Record-Herald, by William E. Curtis, under date of November 10, 1907, contains the following paragraph:

When the Attorney General convicts the Cotton Growers' Association of conspiracy in restraint of trade and sends all the planters in the South to jail, he will then proceed against the medical associations of the country, which have fixed the fees that physicians shall charge their patients. That is clearly in restraint of trade. Every doctor belonging to an association is compelled to make out his bills according to a schedule fixed by the association; he is not allowed to do business any cheaper and the public cannot secure medical attention without submitting to the exactions of this great trust. And that is what he means when the President says there are good trusts as well as bad trusts.

This coming from so distinguished an authority as Mr. Curtis,



may lead many people to think the Medical profession has formed a trust.

The medical profession is better organized today than it ever was, and this organization was not accomplished for the purpose of raising fees or adopting any schedule of fees, but that we may become more proficient in our profession, and command the respect that is due to the science of medicine. While there has been in recent years increased cost in the expense of living, and increase in the price of labor, the doctor has accepted the same fees that were established twenty-five years ago. Mr. Curtis should investigate before making such sweeping charges.

**Meeting of The Council.**—The council of the Kansas Medical Society met at the Grund Hotel, Kansas City, Kan., December 27, 1907. Those present were Drs. J. E. Sawtell, President; Chas. S. Huffman, secretary and L. H. Munn, treasurer. Councillors present: C. C. Goddard, First district; H. B. Coffey, Second district; A. J. Furst, Fourth district, and Preston Sterritt, Seventh district. All councillors present made verbal reports as to the condition in their respective district. The reports as to the condition of the county societies were favorable. A few counties have found it difficult to keep up their organization. The reports show that it requires constant hard work on the part of the councillor to keep up their interest in the county societies. This brought out the fact that the councillor districts are too large, and it is impossible for any one man to do all the work that should be done in a district. It is due Dr. O. J. Furst of the Fourth district the credit of calling attention of the council to the size of the councillor districts and that the state ought to be re-districted. Much more effective work could be done if we had smaller districts. At the state meeting Dr. Goddard and Dr. Garrett were appointed a committee to go to Iola and consult with the Eagles relative to lodge practice. Dr. Goddard reported that nothing could be accomplished at that time. He also reported that he visited Brown County, where complaint had been made that a physician in good standing in Douglass county had assisted and helped an irregular living in Brown county, and that Brown county society wanted the Douglas county society to prefer charges against the member who had assisted the irregular. The council will await action by the Douglas county society.

The matter of editor was deferred until the meeting of the State Society. Iola was selected as the next place of meeting of the State Society, which will be May 6, 7, 8, 1908. Council adjourned.

**SOCIETY REPORTS.****The Sumner County Medical Society's Second Annual Banquet.**

The Sumner County Medical Society held their second annual banquet at Wellington, Thursday evening, January 1, 1908. An excellent program was prepared for the evening, as well as a sumptuous spread. The following is the list of officers and members of Sumner County Society:

**OFFICERS.**

F. M. Owens, Argonia, President.

Mel Collins, Oxford, Vice President.

J. M. Hunt, Wellington; E. A. Evans, Conway Springs; F. G. Emerson, Wellington, Censors.

W. H. Neel, Jr., Anson, Delegate.

T. H. Jamieson, Wellington, Secretary-Treasurer.

**MEMBERSHIP.**

S. T. Shelly, H. B. Morton, H. A. Vincent, W. H. Neel, Sr., Eugene Pile, F. B. May, Melvin Collins, W. S. Bartlett, E. G. Farris, J. J. Shippey, E. A. Evans, F. M. Owens, D. E. Kissecker, T. H. Jamieson, I. T. Gabbert, J. L. Halliday, J. F. Robertson, F. G. Emerson, E. M. Williams, L. F. Harmon, J. M. Hunt, H. E. Hoke, J. C. Robb, S. W. Spitler, R. H. Shippey, J. A. Rea, G. R. Waite, H. L. Cobean, W. H. Neel, Jr., W. M. Martin, R. A. McIlhenny, T. J. Hollingsworth, Walton Rea, Robert Downing, G. L. Millington, L. S. Coplean, Probationer, Dr. Dildine.

**Cowley County Medical Society, Arkansas City, Kansas, December 16, 1907.****OFFICERS.**

F. H. Guinn, President.

Willis H. Hall, Vice President.

O. B. Wyant, Treasurer.

H. L. Snyder, Secretary.

**PROGRAM.**

1 President's Address—"Suggestive Therapeutics and Ethical Quackery", Dr. J. H. Guinn, Arkansas City.

2 Paper—Treatment of Scarlet Fever, Dr. B. C. Geslin, Arkansas City.

3 Paper—Causes of Imbecility, Dr. I. N. Clark, Winfield.

4 Paper—Hypodermic Anesthesia, Dr. R. W. James, Winfield.

5 Opsonins, Dr. R. Claude Young, Arkansas City.

Election of Officers for 1908.

Payment of dues for 1908.

Other business of importance.

**SHAWNEE COUNTY**

Editor Journal—The annual meeting of the Shawnee County

Medical Society was held December 21, at the Throop hotel. About two-thirds of the society's membership was present. The application of Dr. L. B. Bushong was approved and he was elected a member of the society.

New officers for the year 1908 were elected as follows: Dr. D. E. Esterly, president; Dr W. E. McVey, vice president; Dr. W. A. Wehe, treasurer; and Dr. J. B. Tower, secretary. Dr. O. P. Davis was elected member of board of censors.

The report of the treasurer, Dr. Wehe, showed the society to be in a prosperous condition, with 63 members in good standing with all dues paid.

Dr. W. C. McDonough, the outgoing president, delivered the annual message to the society, in which he complimented the society on the work of the past year. He urged the presentation of more clinical cases and a better attendance. He recommended a similar program for the coming year to that of the present one.

After duly installing Dr Esterly, the new president, in the chair, the meeting adjourned to the banquet hall.

J B Tower, secretary.

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#### LABETTE COUNTY

Editor of Journal—The Labette County Society met at the Mathewson hotel last night, for the annual election of officers. The following were selected: President, Dr. Geo. Leggett, Oswego; Vice President, Dr. Geo. Maser, Parsons; Secretary and Treasurer, Dr. O. S. Hubbard, Parsons; Delegate, Dr. E. W. Boardman, Parsons; Censor., Dr. A. D. Smith, Parsons. Preceding the election the following program was given:

Dr. Maser demonstrated a case of detached retina due to trauma, upon which he had operated with great improvement in function. He also demonstrated an enucleated eye, which, on being opened, was found to contain a large steel splinter.

Mr. Chas. Kimball gave a talk on legal medicine, which was much appreciated by the society.

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#### ALLEN COUNTY

Editor Journal—The Allen County medical Association met on their regular meeting night in the court house, Iola, Kan., Wednesday evening, December 18, 1907, and after listening to a very interesting review of the current month's medical literature by Dr. Heylmun, elected the following officers for the ensuing year: Presi

dent, F. H. Martin, Iola; Vice President, J. H. Hindman, Humboldt; Secretary, P. S. Mitchell, Iola; Treasurer, D. W. Reid, Iola; Censor, C. W. Rennick, Gas. Secretary's report for year was read which showed a very prosperous year with everything encouraging for the future. Routine business was disposed of, in which a very interesting feature came up that might interest some. It was unanimously decided by the association that a committee be appointed to wait on the county commissioners and inform them that with their consent the association in the future wished to take care of the "official" pauper practice and the money be paid into the association treasury. If this meets with the approval of the commissioners and they accept, the association will have a constant fund on hand to support laboratory, library and a place of their own in which to meet. I would like to suggest the experiment to other societies. We have been working on this for several months and the report from the Tuscola (Mich.) society renewed our interest.

P. S. Mitchell, Secretary.

### MONTGOMERY COUNTY

Editor Journal—The physicians of Montgomery county held their annual meeting at the Carl-Leon yesterday, and at the conclusion of the sumptuous banquet served by Host Hines of the Carl-Leon last evening, it was voted that the wives, or those who have wives, should participate in next year's feast. Those who have not wives, of course, will be expected to make arrangements between this and the time of the next gathering.

Out of sixty invitations mailed by Doctor J. R. Scott twenty-eight responses were received, and the meeting was both a social and scientific success.

The following officers were elected for the following year:

President, Dr. H. M. Casebeer, Independence.

Vice Presidents, G. M. Seacat, Cherryvale; I. B. Chadwick, Tyro; G. J. Bigelow, Caney; Mary S. Martin, Coffeyville.

Secretary, W. C. Chaney, Independence.

Treasurer, W. E. Young, Cherryvale.

Member Board of Censors, C. E. Wickersham, Independence.

Applications for membership were received from the following physicians:

Coffeyville, C. E. Grigsby, G W Brown, L A Jacobus

Independence, J T Davis, J E Dwyer, E A Miner, B F Taggart, W S Hudiberg

Elk City, J T Blank, J. N. Strawn.



LeHunt, J. N. Davis.  
Liberty, M. J. Williams.

### WILSON COUNTY

Editor Journal—The Wilson County Medical Society met at Fredonia December 10th. Meeting called to order by Dr. A. H. Rogers in absence of the president. Roll call showed six members present besides Dr. W. H. Young of Fredonia—a visitor—but afterwards a member.

A paper by Dr. F. K. Day of Neodesha, on general anesthesia, was presented and it covered the ground most thoroughly. An informal discussion followed, in which all present took part. One speaker was of the opinion that chloroform was used too frequently in obstetrical work. For sometime he had been using forceps when indicated without giving chloroform or any other anesthetic, and it was the opinion of the speaker that very few cases of even forcep delivery required an anesthetic. His views were not shared to any extent by those present. The new and extensively advertised anesthetic—H. M. C., of Abbott—was thought worthy of further and careful investigation. Dr. L. L. Jones of Altoona, had a cyanotic baby after giving one half strength tablet. Later he did not have the same trouble. Dr. Young spoke of having a cyanotic baby his first experience, but the second time after having given two full strength tablets and a quarter grain of morphine besides he had a bouncing baby. The trouble with the majority of the reports on the H. M. C. combination read something like this: "Have used her in a number of cases and she is a dandy", not giving indications or results and leaving the reader completely in the dark.

On motion of Dr. L. L. Jones, it was decided to make a program for the year 1908, divide the membership into sections of four, beginning at the "A's", assigning the members of Section One to read papers at our February meeting, Section Two at our April meeting and so on through the year. The members are to choose their own subjects early in the year and notify the secretary.

An invitation was extended to Dr. W. H. Young to join our society. He stated that he was a member of the Kansas Electric Society, wished us to know that, before we took action on his application. It was quickly and unanimously decided to admit him one among us.

Dr. T. Blakeslee of Neodesha was granted a life membership in our county society.

The treasurer's report for 1907 read and accepted. It showed \$56.00 collected, \$38.00 remitted to state society and \$3.50 incidental expenses, leaving a balance on hand of the 1907 business of \$14.50. Five members paid their dues for 1908, which is not included in this report.

Nominations being in order for officers for ensuing year Dr. W. H. Addington of Altoona was elected president; Dr. A. H. Rogers, vice president; Dr. E. C. Duncan, secretary and treasurer; Drs. F. K. Day, L. L. Jones and A. C. Flack, censors.

The dues should be sent to the secretary within the next thirty days; they should be in the hands of the State Secretary in January.

Meeting adjourned to meet at Fredonia second Tuesday in February.

Fraternally,

E. C. Duncan, Secretary.

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### CHEROKEE COUNTY

Editor Journal—My Dear Doctor:—The Cherokee County Medical Society held its annual meeting in Galena, Tuesday evening, December 10th. As our president, Dr. Scoles, was unable to leave home on account of sickness, the meeting was held at his residence. Several members were present from the northern part of the county. The secretary's report showed a good balance in the treasury to the credit of the society and thirty-one members in good standing. The program committee reported a program for the coming year, which was adopted. Dr. McClellan reported a case of traumatic arthritis with details of treatment, which elicited a lively discussion. Dr. Lowdermilk read a paper discussing the general technique of Minor Surgery as done by the general practitioner. The society voted to make Galena the regular place of meeting, and to hold all meetings there unless otherwise directed by vote of the members at subsequent meetings. Election of officers resulted as follows: President, Dr. J. P. Scoles, re elected; Vice President, Dr. J. H. Green; Secretary-Treasurer, Dr. R. Claude Lowdermilk, re-elected; Member Board of Censors, Dr. Geo. B. McClellan. As there are only about fifty physicians registered in the county we consider our membership of thirty-one a very creditable showing.

R. Claude Lowdermilk, Secretary.

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### LEAVENWORTH COUNTY

Editor Journal—At a meeting of the Leavenworth County Med-

ical Society held on the 9th of December the following named officers were elected for 1908: R. L. Boling, president; J. W. Risdon, vice president; Chas. J. McGee, secretary; Chas. E. Brom, treasurer. Meeting adjourned until the second Monday in January.

Chas. J. McGee, Secretary.

#### RICE COUNTY

Editor Journal—The Rice County Medical Society met at Lyons Decmeber 19 and elected the following officers: President, J. S. McBride, Lyons; Vice President, J. H. Powers, Little River; Secretary-Treasurer, H. R. Ross, Sterling; Censor, E. C. Fisher, Lyons. The society voted to arrange for a joint meeting with Barton, Reno and Ellsworth counties to be held at Lyons.

Arrangements were made to have programs printed for the year. This plan has been followed the past two years and has proven a success. The society is in a prosperous condition and anticipates a profitable year's work.

H. R. Ross, Secretary.

#### McPHERSON COUNTY

Editor Journal—McPherson County Medical Society met December 23, 1907, at the court house in McPherson at 2 p. m. Doctors present were J. W. Van Blaricum, L. A. Bradbury and G. R. Dean of McPherson, A. Philblod of Lindsborg, E. R. Smith of Marquette, C. D. Weaver of Galva and J. C. Ulrøy of Windom.

One paper was read on "Infection" and freely discussed. One case was presented as a clinic.

Annual election of officers resulted in E. O. Smith, president; L. A. Bradbury, vice president; J. C. Ulrey, sercetary and treasurer; C. D. Weaver, delegate to meeting with G. R. Dean as alternate.

Society voted to take up the post graduate course as outlined in the J. A. M. A. as far as practicable to do so at its meetings hereafter. A paper on "Bright's Disease" will be read at our next meetiug by C. D. Weaver.

J. C. Ulrey, Secretary.

#### SEDGWICK COUNTY

At the meeting of the Sedgwick Couty Society January 7, Dr. J. D. Clark was elected president, Dr. C. E. Scott, vice president; Dr. W. A. Phares, secretary and treasurer; Dr. J. L. Evans, delegate and Dr. J. C. Brown, censor.

## NEOSHO COUNTY

Editor Journal—The Neosho County Medical Society held its annual election of officers on December 27, 1907. The officers elected by the society for the ensuing year are as follows: President, Dr. J. B. Edwards; Chanute; Vice President, Dr. A. M. Davis, Chanute; Secretary, Dr. R. A. Light, Chanute; Treasurer, Dr. J. C. Lardner, Chanute; Censor, Dr. R. C. Henderson, Erie; Delegates, Dr. R. A. Light and Dr. T. R. Edwards. The society is thriving and growing.

Fraternally,

R. A. Light, Secretary.

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**ABSTRACTS.****The Decline of Medical Incomes.**

From The St. Louis Medical Review for April 27, 1907.

The American Medical Journalist for March contains a forceful editorial article on The Decline of Medical Incomes. The writer does not agree—neither do we—to the thesis that it is all due to the nostrum vendors and the proprietary medicine men, but accuses such important factors as “the unprecedented increase in recent years of free hospitals, dispensaries and clinics;” the “establishment of many more teaching institutions than is necessary or desirable;” and the “fearful lust for surgery.” In all these things the profession itself is primarily to blame. In the first case “the feverish desire of medical men to be identified with institutional work” alone renders it possible for these quasi-charities to obtain the necessary financial support. The irresponsible and unendowed medical colleges, which exist primarily that certain medical men may get ahead of their colleagues by virtue of the public prestige attaching to a “professorship”, must have students, in order to exist, so they overcrowd the profession with medicos fitted neither by temperament, character, ability, nor preliminary education. As to the last cause, “hundreds, even thousands, of doctors, competent or not, have aspired to be surgeons” as bringing greater returns, both in kudos and cash, and have thus driven numbers of people to turn aside to irregulars of all kinds who have not been slow to seize the opportunity. The author continues:

“The fact is that the medical profession must awake and get down to fundamentals. Every doctor must recognize that his primary function as a medical man is to meet the needs of the sick. This means to be useful



rather than brilliant, resourceful rather than prejudiced, broadly intelligent rather than dogmatic. . . . Above all it means less cant, criticism, and conflict between doctors themselves, and a more ready acceptance of every intelligent idea, method, or remedy, no matter what its source, that will make today's results a little better than those of yesterday."

We cannot endorse too strongly the following words quoted from an editorial in the New York Medical Journal for February 9th:

"Wisdom is better than learning in many of the affairs of our daily life, and to say this is not in the least to depreciate scholarship, for it must be recognized that so far as medicine is concerned, science can never wholly part company with intelligent empiricism."

To us it seems that the root of the evil lies deeper than has been suggested yet. It lies, in our opinion, in vicious early training, which neglects the individual standard of self respect.

Youth is taught to plant its self respect on the platform of a comparison between itself and others, instead of on measuring up to the standard of its own individual highest possible capacities, moral, mental and physical, without reference to those of others, one or many. This creates a false standard of success, so that there is fostered a desire to be thus and do so, because others are thus and do so, and not because thus and so necessarily fulfill one's highest judgment as in themselves desirable. One is on the stage all the time and one's mind is centred on "how it looks from the front." And so one schemes for wealth, more or less, not to fulfill actual needs of one's individual nature or to enable one to follow in absolute independence one's own high ideas, but to "keep up with the procession." This may do in commerce, which (commerce—not necessarily commercial men, with who the matter is a purely individual one) has no ideals at all worthy of the name, but it is high treason to the majesty of any true profession. To the true professional man the opinion held of him by fifty thousand is of no whit more importance than that held by one, unless it can compel the assent of his own convictions in each individual instance.

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## NEWS AND NOTES.

### Training in Medical Organization.

The students of the University of Pennsylvania Medical School have formed an organization the purpose of which is to acquaint the undergraduates with the workings of the American Medical

Association, after which it is very closely modeled. The various societies take the place of the state organizations and elect members to a House of Delegates, which transacts all the business of the association. An annual meeting is held at which papers are read by chosen members, thus encouraging research and a scientific spirit. The organization is named The Undergraduate Medical Association of the University of Pennsylvania, and already has over two hundred and fifty members.

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### **Fake Fight Bankrupted Him.**

Salina, Kans, Jan. 6—Involuntary bankruptcy proceedings were filed with Referee Z. C. Milliken here this morning against Dr. C. E. Nelson of Phillipsburg, Kans. The liabilities are about \$25,000, and Dr Nelson says the assets will amount to \$30,000. Dr. Nelson has been one of the most widely known physicians in Northern Kansas for years and was known as a breeder of fast horses. He was the victim of a band of swindlers in Denver about two months ago and lost \$9,900 of borrowed money on a bogus prize fight. Before the money borrowed was due the money panic developed, and inability to borrow or to dispose of his property forced him into bankruptcy. All of his property was placed in the hands of a receiver a few days ago.—From the Kansas City Star, Jan. 6, 1908

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The following articles were added to the list of new and non-official remedies prepared by the Council on Pharmacy and Chemistry, which was published in the Journal January 4: Guaiacol Carbonate Comp ..(H.. K. Mulford Co.) Neuro-Lecithin (Abbott Alkaloidal Co.)

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### **BOOK REVIEW.**

**The Perpetual Visiting List** and pocket reference book, including information in emergencies; published in St. Louis by J. H. Chambers & Company.

This is a cloth bound folder containing an undated weekly call list, a few lines for monthly memoranda, four pages for clinical memoranda, a page for nurses' addresses, six pages for an obstetrical record, two pages of birth records, two pages of bills rendered, four pages of cash received, six pages of miscellaneous memoranda, one page of death records, two pages of vaccination records, two pages for articles loaned, and one page for cash loaned. It contains also a dose table, the poisons and their antidotes, and some direc-

tions for artificial respiration.

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**A Treatise on the Diseases of The Skin**, Henry W. Stelwagon, M. D., Ph. D., Professor of Dermatology, Jefferson Medical College, Philadelphia. Fifth edition. This is a book of 1150 pages with 67 text illustrations and 34 full page and halftone plates. Published by W. B. Saunders & Co., Cloth \$6.00 net; half morocco, \$7.50 net.

One notes in this last edition that the additions consist mostly of those prevalent in the tropics notably dhobie itch uncinariar dermatitis tinea imbricata and verruga peruana. There are fifteen new illustrations. In the subject matter the treatment in accord with present tendencies, is given most consideration. The author not only states what he believes is best for the disease, but tells definitely how to use the remedies to best advantage. Symptoms are given with the author's previous carefulness in detail and completeness, which makes up in large part for the lack of differential diagnosis. The index is complete with common names as well as the Latin so that one readily finds what he is looking for. All in all the book shows considerable improvement over the old editions which have been standard texts on this subject. S. C. E.

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### **Used in Miscarriage—Just What Was Wanted.**

I find your H-M-C hypnotic anesthetic just what I have wanted for some time, and will keep a supply always on hand. In miscarriage where the placenta must be removed under anesthesia they are the very thing and relieve the operator of the worry of chloroform or ether. I believe them superior to the morphine and atropine hypodermic as more lasting and certain in effect.

Dr. A. D. Barnett, Guilford, Mo.

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### **Greatest Accessory of Modern Times.**

I used your H-M-C tablet in operating for ventral hernia. A previous operation failed to get union. I handled the intestines for a lesion and in closing the wound lapped the muscles well and used strong staple sutures after the Mayo method for umbilical hernia. I gave one tablet two and a half hours before operating, repeating in a half hour. During one hour's work she inhaled only twenty drops of chloroform, and could have done without that; especially if I had given the third tablet. This combination is destined to be one of the most important accessories to capital surgery in modern times.

J. M. Inge, M. D., Denton, Texas.

### H-M-C in Texas.

I used Hyoscine Morphine and Cactin Comp. upon two tough cases, one an old man of sixty-five, with renal colic; and allow me to go on record as saying it relieved him completely within fifteen minutes. The other was a Mexican who had had singultus for three days and I had given all of the remedies I thought of, read or heard of with no results. He was growing worse. In just three minutes after this first dose he stopped hiccoughing to stay stopped. I am inclined to the belief that H-M-C Abbott will be a greater boon to humanity than chloroform or ether because of its so much wider range of usefulness. Dr. B. R. Bradley, Hondo, Texas.

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### Various Hospital Cases.

Case 1. Enucleation of eye in hospital. The patient did not know she had left the ward; could not believe operation had been performed. About two drams of ether used. Prompt recovery.

Case 2. Appendectomy in hospital. Man, 68, did not know he had been from ward for operation; felt fine after it, no nausea, very little ether given, usual recovery.

Case 3. Private, perineorrhaphy. Asleep before second hypodermic injection; did not know of taking the little ether and could not realize operation had been done. Perfect result.

Case 4. Obstetrics, primipara, breech presentation, very nervous, calling for chloroform. Gave one H-M-C hypodermic injection, within fifteen minutes a change; took things easy, worked with pains, forceps applied, had difficulty bringing down arms and delivering head, but as she did not resist, but helped herself, we finished in time to save the child. No perineal tear, normal recovery. I think it a fine combination.

Many other hospital cases similar to those reported.

E. W. Smith, M. D., Meriden, Conn.



**The Injection Treatment of Neuralgia.**

International Journal of Surgery.

Dr. E. Schlesinger states that while injections of alcohol into the nerves are adapted for neuralgias of the sensory nerves, they are attended with risk in the case of nerves having a mixed function, such as the sciatic, as they may cause paralysis. By injecting fluids at ordinary temperature into the vicinity of nerves according to the suggestion of Alexander prompt relief is afforded but even better results may be obtained by cooling the injection fluid. In case of sciatica, Schlesinger now injects a saline solution at a freezing temperature in amounts of 10 ccm. into the painful points. If the sciatica is of chronic character, the painful points are found about the trochanter and the crest of the ilium. Even in obstinate cases immediate relief of pain is produced, and should it later recur another injection is sufficient to cause its permanent subsidence. In his opinion 70 per cent. of all neuralgia are either of gouty or diabetic origin, a fact which is not sufficiently well-known. This method is also adapted for the treatment of supraorbital neuralgias coccygocynia and tee girdle pains of tabes. According to Dr. Alexander the temperature of the injected fluid must be less than the bodily temperature, but he had found it impossible to inject a fluid of lower temperature than that of the room, as it immediately assumes that temperature as soon it is drawn into the syringe.

# THE JOURNAL

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### TABES DORSALIS.

By H. P. MAHAN, M. D., Parsons, Kan.

Tabes dorsalis or posterior sclerosis is a disease that affects the posterior columns of the spinal cord, sensory nerves, posterior nerve roots, and often produces changes in the medulla and cerebrum.

One of the principal causes is syphilis, although a definite history of syphilitic infection cannot always be obtained. Alcohol, exposure to cold, acute fevers, lead and arsenic, have been said to be a cause, but little is known of them. Tabes rarely develops before twenty-five years of age; the greater number appear between thirty to forty-five. The male sex is ten times as frequently affected with tabes as the female. Race seems to play some role in the production of tabes, as negroes are rarely affected although syphilis is quite common among them. Many theories have been advanced as to the pathogenesis of tabes: 1. The toxemic theory of syphilis; 2. The strangulation theory of Obersteiner and others who find the initial factor in pial thickening whence arises the posterior root and cord changes. 3. Marie's latest contention is that changes start in a lymphangitis of the posterior columns of the cord.

The pathological findings consist of a degeneration of the posterior columns which are the columns of Goll and Burdach. As the disease is one of ascending degeneration, their nuclei, which are located in the medulla, sooner or later show degenerative changes. Cranial nerves are also involved. Degeneration in the posterior spinal nerves would produce some disturbance in the skin, muscles and joints. The sclerosis are most marked in the lumbar cord. The cerebral changes are those of atrophic degeneration.

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Read before the Kansas Medical Society, February 1908.

has a close relation.

Probably no disease of the spinal cord presents so many symptoms as posterior sclerosis. Among the earliest of these are the lightning pains most commonly felt in the legs, but may be complained of in other parts of the body. The patient often describes the condition of his legs as being numb, weak, or heavy. Another type of pains appearing during the course of the disease is the girdle sensation. The patient complains of a feeling of constriction about the gastric region which he tries to relieve by loosening the clothing. Analgesia are of frequent occurrence, being sometimes well marked in the lower extremities and a pin may be thrust through the skin without the patient complaining of any pain. Delayed sensation is quite common. The contact of a point may be felt at once, but the pain only after a short interval. The motor symptoms are the most striking features and the ones that usually attract the greatest attention of the patient. The muscular sense being impaired, they cannot determine the place or position of their limbs without the aid of vision. The ataxic gait that develops as the disease progresses is quite peculiar; on walking the foot is thrown forward, the heel brought down suddenly, the toe striking the floor almost at the same time. With closed eyes and feet together the body sways from one side to the other as if about to fall, presenting what is known as the Romberg sign.

Most of the reflexes are diminished or abolished. The most important reflex lost is that of the patellar. This occurs in about ninety per cent of all tabetics and may be one of the early symptoms. The pupillary changes that are usually present are inequality, small contracted pupil and loss of the iris reflex to light with accommodation still retained (Argyll-Robertson pupil). Optic nerve atrophy occurs in from ten to thirty per cent of all cases, is usually bilateral and terminates in total blindness. Some authorities say that cases developing optic nerve atrophy early do not show much ataxia.

The gastric disturbances that sometimes appear early consist of pain and vomiting, and are often mistaken for other conditions until some of the more pronounced symptoms develop. Urinary symptoms may be one of the earliest to develop. Chief among these are the difficulty in starting the flow and completely emptying the bladder. Catheterization may have to be resorted to, and care should be taken in this procedure as cystitis may occur.

Spontaneous fractures sometimes occur without much violence. They are not very painful and union takes place as in ordinary fractures. Tabetic joints are marked by abnormal range of motion, and there is also present enormous swelling of the parts. Bedsores and ulcers appear sooner or later and, though they are painless they require careful attention.

The progress of the disease is slow, often requiring many years before marked symptoms develop. The usual course is for the patient to develop the first stage (of pains) and go on slowly after three or four years to the stage of ataxia, and remain in that stage for fifteen or twenty years, and then become totally helpless. This typical course is not conformed to in all cases, however, as the stage of ataxia may come to a standstill after a very slight inco-ordination has developed and the patient remain slightly ataxic for a number of years. Double optic nerve atrophy may appear and the stage of ataxia may never develop.

The diagnosis of this disease would not be difficult if all the symptoms were present. When the sensory disturbances precede the motor, which as a rule they do, the diagnosis cannot be made until some of the more cardinal symptoms appear, but when the ataxic gait, lost patellar reflex, and Argyll-Robertson pupil are present, the diagnosis can be firmly established. It usually requires many years for all these signs to develop.

Among the diseases often confounded with tabes is multiple neuritis, but the absence of girdle sensation, urinary disturbances, and pupillary changes, also the history of some toxic agent and the tendency to recover should differentiate it from tabes. Multiple sclerosis has its cardinal symptoms—intention tremor, nystagmus and scanning speech. Cerebellar tumor would present choked optic disc, occipital pain, no interference with sensation and often exaggerated reflexes.

The prognosis is unfavorable as to recovery, yet a considerable number of tabetics live many years after some of their symptoms have developed, and are able to continue their occupation and are finally carried off by some intercurrent affection.

In the treatment too much must not be expected. Granting that syphilis is a great causative factor in the production of tabes, specific treatment should be carried out if the case is seen early with the idea of preventing further progress of the disease, but after the symptoms are well developed it is a question if anti-syphi-



litic treatment does much good. This would tend to emphasize the necessity of putting all syphilitics on specific treatment for a considerable length of time.

The general health should be improved, if possible, by a change of climate, nutritious diet, proper hygienic surroundings and tonics if necessary. The nutrition of the cord should be improved. Local application to the back, massage, thermo-cautery, etc., may be used, but it is doubtful whether or not anything is accomplished by them. The patient should be encouraged to practice certain exercises that tend to improve co-ordination. It is only of late years that these procedures have been employed and in this way they may sometimes be able to walk after ataxia has been well developed.

The chief indications for treatment are the pains and visceral crises, and these should be relieved with local application if possible. Among the drugs that may be tried are phenacetin and antipyrine, but as a rule they will not control the pains and as a last resort morphine will have to be used. Urinary antiseptics should be employed to prevent cystitis. If self catheterization is resorted to the patient should be instructed how to do this with care and cleanliness. Encourage the patient as much as possible and meet all the incidental affections as they arise.

## SURGICAL TREATMENT OF TUBERCULOSIS.

By R. M. MARKHAM, M. D., Scanmon, Kansas

The history of tubercular affections of the bones and joints is quite an extensive one and one that the rural physician as well as the city physician should be conversant with as he is as likely to come in contact with it as those practicing in the cities, especially those practicing where a great number of foreign emigration has settled. The germ of tuberculosis attack most every part of the human anatomy hence the field is a great one so I will take up that of the bones and joints.

During the time of Hippocrates some general facts were understood, such as that phthisis develops more or less directly after certain surgical accidents or diseases, but nothing definite was known. Less than a century ago we find chronic inflammatory affections of bone designated by such vague terms as Spina-Ventosa, Osteospongiosis, etc. Tuberculosis of bone as we now understand it was described by Boerhave as a destructive process in the epiphyses extending from within outward, some regarding it as a caries commencing in the interior of the medullary canal. Augustine defines it as an inflammatory process, in the interior of the bone which brought complete textural changes, other authorities had their opinions as to the nature of the disease, but the first actual clinical picture of a tubercular joint was drawn by Wiseman which he called white swelling or tumor albus. Since his time (1676) until recently, and to a certain extent even at the present time, it has retained its place in surgical nomenclature. Under this term he grouped all joint lesions, characterized by chronic inflammation and enlargement of a joint and maintained that in the majority of cases it was caused by scrofula. Bell of Edinburgh taught that tumor albus may be caused by a trauma scrofulous or rheumatic inflammation. Later other investigators held that tubercle may appear as a circumscribed or diffused lesion and that many chronic suppurative lesions in bone originated in tubercular foci.

Theories were advanced and discussed; microbes were found and described, which were supposed to bear a direct etiological relationship to tuberculosis but nothing definite was known on the subject until Robt. Koch, the father of bacteriology, in 1882, an-

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Read before the Cherokee County Medical Society.

nounced to the profession his great discovery of the bacillus of tuberculosis.

The tuberculo-bacillus has a special predilection for the medullary tissue of the bones and especially for the red medullary tissue in the constellated tissue in the region of the epiphysical cartilage of the long bones, and some of the short bones, notably the vertebrae and the carpal and tarsal bones. As to the etiology of bone tuberculosis, heredity is an important factor in the causation of bone tuberculosis, as well as tuberculosis of other organs, a hereditary predisposition to tuberculosis exists and has for years been quite generally accepted as a well established clinical fact. By this is meant a peculiar vulnerability of the tissue and a susceptibility to tubercular infection. During the early stage of tubercular inflammation of bone the first local symptoms are often referred to the nearest joint and in osteo-tuberculosis of the hip to the knee joint. The general symptoms are often no indication of the existence or extent of the local disease, as patients with quite extensive bone tuberculosis may present every appearance of perfect health and a small osseous focus may produce a rapidly fatal miliary tuberculosis.

Febrile reaction is slight or entirely absent, if the thermometer shows a normal or subnormal morning temperature and a slight rise toward evening, if not more than half a degree, but continues for weeks and months it indicates a careful search for a local tubercular focus. Progressive anaemia is always an unfavorable symptom in all forms of local tuberculosis as it indicates the presence of additional foci in important organs.

Pain is an almost constant symptom, but varies in intensity, unlike in acute suppurative inflammation of bone, the inflammatory product does not give rise to the same degree of tension; hence, pain is not so prominent a symptom. The primary exudation and transudation in tubercular inflammation are always scanty, and the inflammatory product is composed mostly of granulation tissue derived from pre-existing fixed tissue sells; at the same time the surrounding bone tissue becomes osteoporotic, and yields more readily to pressure. Consequently, tension is to a great extent avoided and pain is slight as compared with the acute and intense suffering caused by acute osteomyelitis.

It may be stated as a rule that the intensity of the pain bears a direct relationship to the acuteness of the inflammatory process. The pain is of a dull aching character and is intermittent and more

severe during the night. The nocturnal exacerbation of the pain, as evidenced in children by restlessness during sleep, moaning, grinding of teeth and horrible dreams, is often one of the first symptoms which excites suspicion of the existence of osteo-tuberculosis. Pain is not always referred to the seat of lesion.

Tubercular osteomyelitis of the head and neck of the femur gives rise to pain in the region of the knee joint, which is intensified by movements of the hip joint, or by making pressure on the great trochanter, while manipulation of the knee joint, if the hip joint is immobilized, does not increase it. Children suffering from tuberculosis of the spine usually refer all suffering to the pit of the stomach, or to some other part of the abdomen supplied with nerves that take their exit from the spinal canal at a point corresponding to the inflamed vertebra.

The periosteum covering the bone overlying an osseous focus at a comparatively early stage of the disease becomes the seat of inflammation before it is reached by the tubercular process.

This circumscribed periostitis gives rise to tenderness. The existence of an area of tenderness over a point corresponding to a tubercular focus in the interior of a bone is one of the surest indications of the existence of osteo-tuberculosis.

Atrophy of bone and muscle is a constant symptom in osteo-tuberculosis, as well as in tubercular synovitis. This atrophy is not due to inactivity altogether but appears to be due in part at least to tropho-neurotic lesions; in making a diagnosis it is well to keep in mind the frequency of tuberculosis of joints as compared with affections due to other causes as rheumatic arthritis and syphilitic arthritis, etc.

Treatment.—The treatment is general; Local; Inter-articular injection and tuberculin. The successful treatment of a tubercular bone or joint affection requires that the patient should receive the benefits to be derived from both local and general treatment. The surgeon should not only make use of every local resource best calculated to cure or remove the lesion, but must also possess and apply the knowledge and skill of an intelligent physician in the treatment of such cases.

The necessity of general treatment, hygienic, climatic, dietetic and medical, must become apparent if as has been shown by clinical experience and postmortem examinations, that the local affection in the bone or joint is in the great majority of cases but a manifestation of the existence of a tubercular focus in another and



perhaps inaccessible part of the body. A failure on the part of the surgeon to institute and carry out a rational course of general treatment would be as detrimental to the patient as a sole reliance upon it in curing the local affection. Both extremes are equally dangerous and should be carefully avoided although it is a familiar fact that tubercular affection of bones and joints manifest an intrinsic tendency to progressive aggravation by local extension and systematic re-infection, cases of spontaneous cure under favorable conditions are by no means rare. It may be laid down as a general rule that whatever contributes towards the improvement of the general health of the patient retards the progress of the local lesion and brings about the most favorable condition for a spontaneous cure, and at the same time greatly adds to the success of operative treatment.

So far we are not in possession of a single remedy which acts as a specific on tubercular tissue as the preparation of Iodine does on syphilitic tissue, general tonic treatment with bitter tonics, cod liver oil, etc.

**Local Treatment.**—Although the existence of a tubercular bone or a joint affection usually is only an indication of the presence of an older tubercular focus in some other part or organ, the clinical fact remains that the primary focus frequently remains in a latent condition and that re-infection is more likely to take place from the bone or joint lesion. It is on this account that the general treatment, no matter how well it may be planned and how admirably executed, can never supplant the necessary local treatment. The local treatment consists of such means and measures which are best adapted to place the affected part in the most favorable condition to undergo a spontaneous cure, and if this, the ideal result, is no longer attainable on account of the extent of the disease or the character of the structural changes which have already taken place the rendering harmless or eliminating of the infected area for the purpose of preventing farther local and general infection, and if possible to restore function of the infected part or limb. The local treatment must therefore vary according to the location and extent of the disease, and the character of the inflammatory product.

During the early stage of the disease, under favorable circumstances the simplest local treatment may prove successful in arresting farther progress and in rendering the necessary assistance to bring about a spontaneous cure, while on the other hand if the dis-

ease is extensive and the tissues have undergone irreparable changes nothing short of a formidable and mutilating operation will answer the indication.

One of the cardinal points in the treatment of inflammatory processes, irrespective of their cause or causes, is to secure for the inflamed part a condition approaching as nearly as it is possible, "absolute physiological rest." While it is necessary to secure rest it can be carried too far and may result in harm, it is one of the most difficult things to decide how long rest should be continued in the treatment of an inflamed joint. No absolute rules can be laid down to decide this matter. Enforced rest carried beyond the time required has resulted in harm in which an early suspension would have yielded better results. Rest is indicated as long as movement causes pain and the pain is due to an inflammation of the structures of the joint. A joint often remains tender and painful for a long time, even after all inflammation has subsided, and it is in this class of cases that the best judgment is necessary to decide when it is best to substitute active and passive motion for rest.

In tubercular hydrops of joints and in fungous synovitis moderate use of the joint does not interfere with the proper treatment for these affections and immobilization in such cases is superfluous and often positively harmful. It is, however, entirely different in osteoarthritis and advanced cases of primary synovial tuberculosis, as in these instances pain is a conspicuous symptom, and is always aggravated by any attempt to move or use the joint.

External local treatment, compression, cold, antiseptic fomentation, massage, counter irritation, electricity, tapping of joint, and tuberculine treatment all have their place; but will not consider them for it will take too much time, but will take up operative treatment.

Operative Treatment.—Arthotomy or incision of a joint has only a very limited sphere of usefulness as a therapeutic measure in the treatment of tubercular joints.

Arthrectomy and Synovectomy are synonymous terms used to designate a modern operation on tubercular joints consisting in the removal of the infected soft structure of the joint and the scraping out of bone cavities, if such are present and communicate with the joint. Volkman's method of performing arthrectomy of the knee joint is as follows: After carefully preparing the patient the operation is commenced by opening the joint by a trans-patellar in-

cision through which the joint can be examined by digital exploration.

If this examination make it appear that it is necessary to extirpate the entire capsule, the incision is extended and the patella divided transversely with the saw. If the bursa underneath the quadriceps is extensively diseased, the incision is modified so as to make an anterior flap, the apex of which corresponds with the uppermost recess of the bursa and the base a little below the knee joint. The bursa is first removed entire and after constitutes a mass of considerable size, the lower extremity of the femur is thus exposed to the extent of three or four inches from the articular surface, the articular and synovial membrane attached to the tibia as well as the semilunar cartilage are removed with the same care, the rule to be observed in these cases is to remove all diseased tissues until healthy bone and muscular tissue are reached. After removal of the soft joint structure the articular surfaces must be carefully inspected, in many cases they can be left intact. Osseous foci that have reached the surface should be removed with spoon or chisel and it may even become necessary to combine the arthrectomy with partial excision. After disinfection of the fragments the patella is sutured with catgut and the external incision closed with the exception of the lower angles which are used to insert drainage, the drains are placed down to, but not between the articular surfaces.

The limb is dressed in a straight or slightly flexed position. This produces a stiff but serviceable limb. This operation has its successes and its failures, its advocates and its opponents.

Resection.—The removal of a portion or the entire articular extremities for injury or disease is called resection. Until quite recently this operation was made by removing both articular extremities, which is called a complete or typical resection to distinguish it from a more modern and conservative operation which aims only at removal of the injured or diseased portion of the articular surfaces and is known as partial or atypical resection. Both of these operations have their distinct and specific indications in the treatment of tubercular affections of joints according to the primary location and extent of the disease. Resection of a tubercular joint is indicated when a primary osseous focus or foci cannot be reached by an extra-articular operation, when the joint has become invaded secondarily and when a primary synovial tuberculosis has extended to the articular surfaces of the bones and the disease has proved re-



fractory to less heroic measures. A great discrepancy of opinion still prevails among surgeons even at the present time, both in reference to the utility of this operation and the proper time when it should be performed. Not a few condemn operative treatment altogether, and pursue an entirely conservative plan of treatment. Others admit that resection is a justifiable operation and assign to it a limited application in their practice but restrict it as a dernier resort, in cases where the disease has far advanced, or where, in consequence of it the general condition of the patient has been seriously affected.

It is not possible to lay down cast iron rules in pointing out the indications for resection as both the local and general conditions must be carefully considered in each case. Unless the general condition of the patient furnish a contraindication it may be stated as a rule that in all recent cases of primary synovial tuberculosis treatment should be commenced with intra-articular and parenchymatous injections of iodoform and if necessary rest and immobilization of limb, and this treatment should be continued for some length of time before an operation is decided upon. If no improvement follows this treatment, or if in spite of it the symptoms become aggravated, the joint should be opened and the condition then revealed will point out whether an arthrectomy or a partial or complete resection should be made. Age furnishes no contraindication to the operation, although the immediate and remote results are much better in children than adults. One of the great questions in connection with resection of a joint is in reference to the extent the structures removed are reproduced after the operation. This subject has an important bearing on the functional results obtainable by the operator.

The tendency at the present time is to devise methods of operation which will leave the parts in a condition better adapted to reproduction of the joint structures removed than was the case after the older operations. It is now the prevailing idea that only diseased tissue should be removed and as little of the healthy bone structure sacrificed as is compatible with a thorough operation. This applies more particularly to operations on joints where it is desirable to procure a movable joint to obtain the best results as on the knee, elbow, shoulder, etc.

Post Operative Treatment.—As the eradication of a local lesion by operative measures seldom, if ever, succeeds in eliminating from



the organism all sources of infection, the local should always be combined with general treatment. As the general treatment has been discussed elsewhere, it is necessary here only to refer again to the importance of carrying it out faithfully and persistently after all operations for tubercular affections, in order to so improve the general health that remaining sources of infection may become harmless after the removal of the principal peripheral focus from which reinfection did or might take place. The knife, saw, sharp spoon, and paquelin cautery must be preceded and followed by efficient well conducted general treatment.

The surgeon must be a physician as well as a surgeon in the successful treatment of such cases. The use of guaiacol, as advised by Schueller, should be continued for three months to a year after operation in doses of two to five drops three or four times a day according to the age of patient. If more attention were given to appropriate after treatment than has usually been the case in the hands of most surgeons, statistics of operative results, both immediate and remote, would present a less gloomy aspect. Improvement of the general health of tubercular patients by general treatment is but calculated to secure a satisfactory process of repair after operative interference, and affords the most efficient protection against local recurrence and general dissemination. In order to secure the best results it is necessary for the surgeon to prepare patients properly for the unavoidable operative treatment, which may require weeks or months, and to conduct the necessary after treatment, not only until the wound has healed, but until the patient has regained his usual health. Sunlight, outdoor air, and a nutritious diet are the best tonics in the building up of tubercular patients. A change of climate is often productive of marked improvement in patients that have recovered from the immediate effects of an operation. Dressings should be changed as infrequently as possible, as such changes is attended by some risk of infection as long as the external wound is not healed completely. Physical and psychical rest is an essential condition in procuring a satisfactory wound healing after operations for tubercular affections. Physical rest is secured by proper mechanical supports of the part or limb operated on, by position and fixation dressings, while psychical rest is obtained by the avoidance of unnecessary pain, and by careful attention to the surroundings of the patient.

Local relapse must be suspected if the wound shows no tenden-

cy to heal and becomes covered in a few days by profuse, soft, almost gelatinous granulation, or if the wound has healed by the characteristic appearance of the cicatrix. The cicatrix, instead of undergoing atrophy and becoming paler from day to day, presents a swollen, oedematus and livid appearance. In a short time the epidermis is destroyed, a whole cicatrix melts away, and its place is taken by pale fungous granulations, which manifest no reparative tendencies. A local relapse calls for prompt operative interference. The granulations should be removed thoroughly with a sharp spoon, a procedure which often makes it necessary to reopen the operation wound in order to reach all of the infected tissues. Such an operation requires all of the antiseptic precautions as the first operation, because tubercular wounds are exceedingly susceptible to infection with pus microbes. The scraping is to be continued until firm, healthy tissue is reached. The wound is now irrigated with strong iodine water, dried, iodoformized, and if large, partially sutured. An iodoform gauze tampon should be used and allowed to remain for at least five days. The part is dressed in the same manner as after the first operation.

Sometimes the operation wound heals in a satisfactory manner with the exception of one or more fistulous tracts. These should be scraped out thoroughly under strict antiseptic precautions, and the operation repeated in four to six weeks if the wound shows no tendency to heal. By following such a course of treatment a resection or amputation may finally be made to heal permanently. Amputation after an unsuccessful arthrectomy or resection may become necessary if the local recurrence is extensive and does not yield to a thorough use of the sharp spoon, or if the resection wound becomes the seat of a suppurative inflammation which proves refractory to free drainage and antiseptic irrigation. A diffuse suppurative inflammation following resection or amputation is best treated by constant irrigation with a saturated solution of acetate of aluminum, free drainage, and covering the parts with a thick hygroscopic compress saturated with the same solution. Authority quoted is Senn on "Bones and Joints."

## **THE CONSERVATIVE TREATMENT OF DISEASES OF WOMEN. WITH ESPECIAL REFERENCE TO RETRO-DEVIATIONS.**

By FRANCIS A. HARPER, M. D., Pittsburg, Kansas.

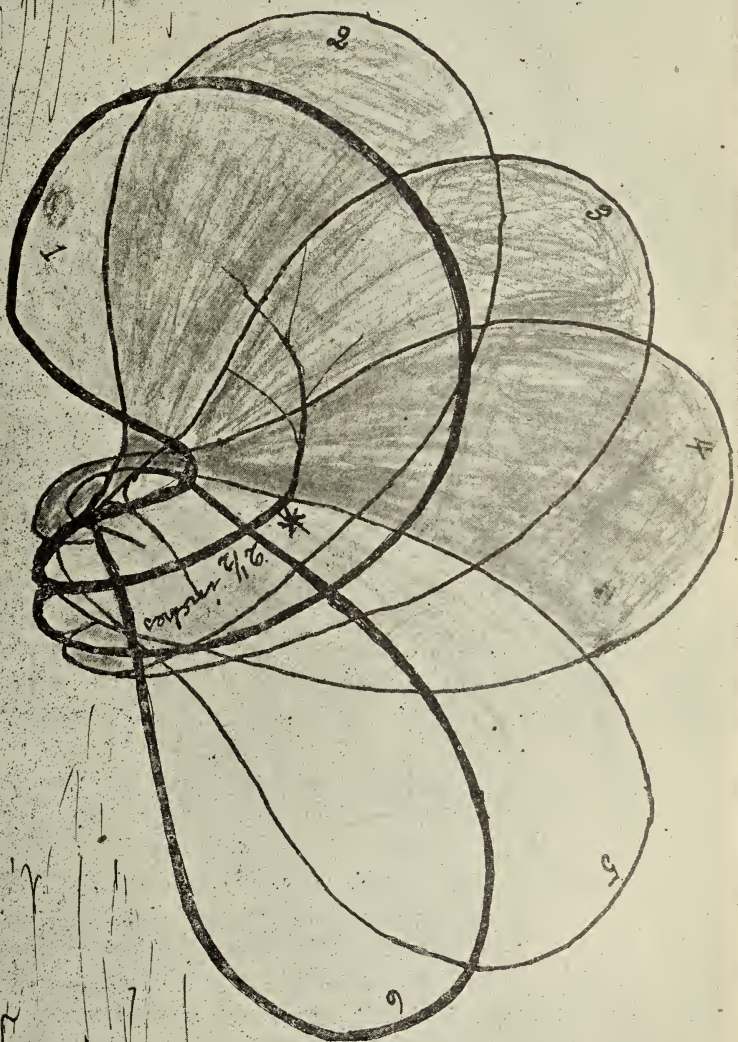
There is probably no class of ailments which is oftener brought to the attention of the medical practitioner—none which so taxes his ingenuity to treat successfully—none which he treats more lightly and which he dislikes more heartily—none which requires more thorough examination and close observation in arriving at a correct diagnosis, and careful thought and keen judgment in selecting a line of corrective treatment—none in which there is so much guessing done, and in which so many “snap shot” diagnoses are made, than in the various pelvic troubles of women—that great class of diseases embraced under the title, “Diseases of Women.”

Eminent medical authorities contribute comparatively little to our periodicals upon this subject, excepting as it is viewed from a surgical standpoint. They discourse learnedly upon the many operative measures in vogue for treating these various diseases, and discuss pro and con radicalism and conservatism in surgery, etc., etc., but for the correction of the many conditions occupying the great intermediate place between a slight functional disturbance or a beginning pathological state, and the gross morbid conditions with which the surgeon has to deal in the operating room—they are silent, or say little, excepting in a generally suggestive way. These ailments among women are so common that they elicit little interest or discussion, until they have developed and perhaps fully ripened into what might be termed the “operative stage”, when immediately they excite attention and interest. Have we not been studying “cause and effect” long enough to be able to recognize the premonitory signs and initial manifestations of unphysiological conditions, and to be able, in a way, to anticipate and thus avoid many of the serious results which experience teaches us are almost sure to develop as a sequence? Are not the cases which come to us in our daily work practical object lessons to us, if we will but interpret them as such, to warn us against carelessness or neglect?

Early and correct diagnosis is of paramount importance, and must rest upon a thorough and practical knowledge of anatomy, physiology and pathology. We sometimes forget these fundamen-

Read before the Kansas State Medical Society.





*Reposition by Manipulation.*  
*(Case I.)*  
*(Hayter)*



tal facts, and too often permit the dust to lie unswept upon our text books, and cobwebs of forgetfulness are allowed to overshadow our minds.

Pelvic pain in women is too often explained as "inflammation of the ovaries." This is a stock phrase with many, and women are taught to eye with suspicion these important little organs from the very time they become aware of possessing them. This so-called "inflammation of the ovary" exists many times only in a too vivid imagination, and the relation they bear to pelvic and abdominal pain is very much over-estimated.

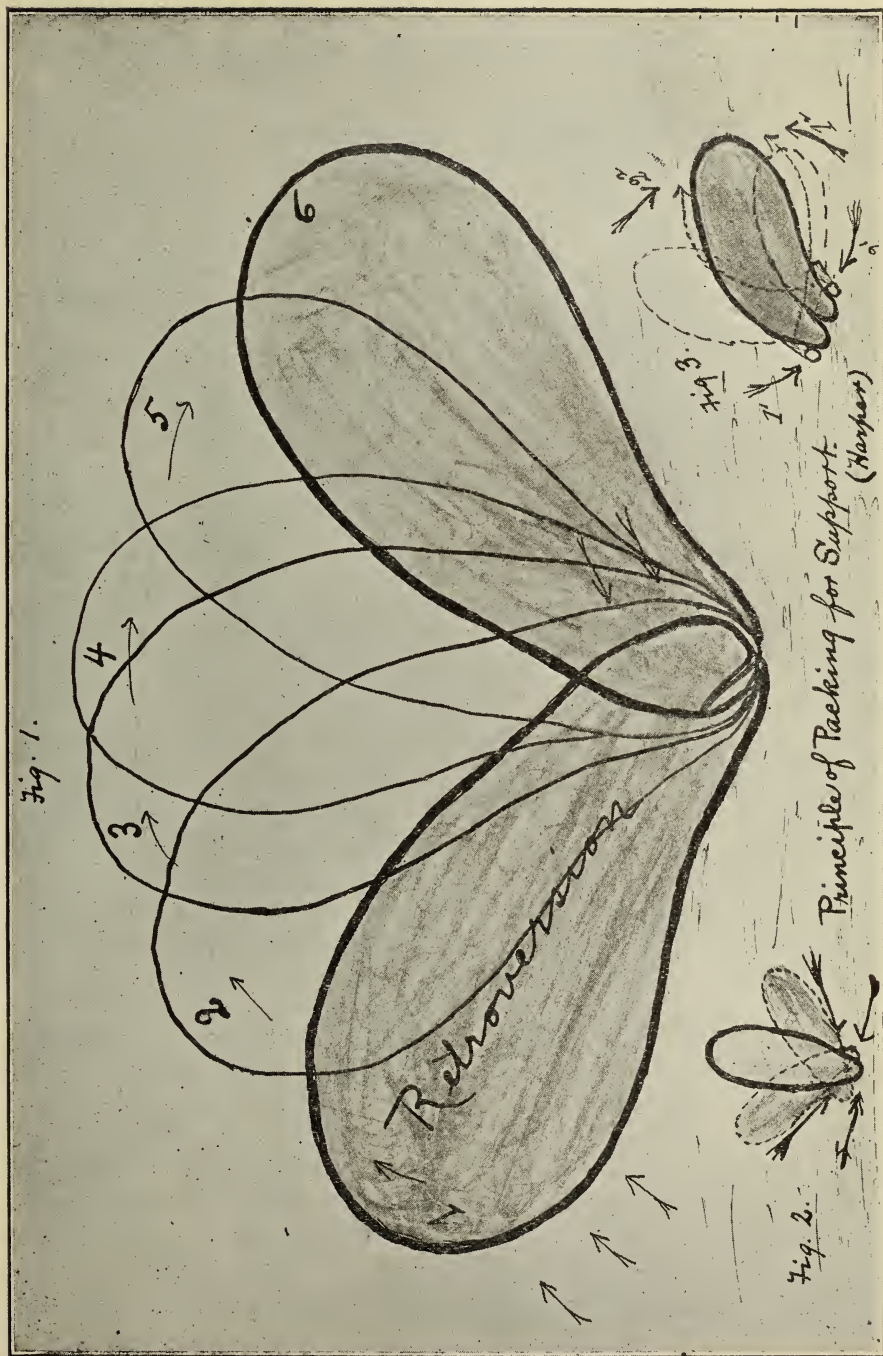
Much has been said recently in regard to the various "functions of the ovary", etc., etc. One of its chief functions seems to be that of a cloak under which to hide ignorant or careless diagnosis. Another, to serve as a convenient peg upon which a woman may hang all her indefinite and otherwise unexplainable symptoms.

If we will but brush off the dust and clear away the cobwebs, and set about cultivating our diagnostic faculties, fewer unnecessary operations will be done—fewer will be needed.

Chronic diseases in general offer unlimited opportunity for the development and training of our diagnostic powers, and especially do the chronic ailments of women, with their varied natures and phases, stages, degrees and complications, give to us a wonderful fertile field for refinements in diagnosis, as well as affording opportunity for wide variation in methods of treatment.

If possible, the pelvic disturbances of women should be recognized and treated in their incipency. Medication and treatment are too often directed toward relieving present indications only, without any special reference to overcoming etiological factors. The dysmenorrhoea of young girls should receive more consideration. Years of needless suffering might be avoided by early recognition and correction of certain pathological states, which are too often neglected, and treated merely as concomitants of womanhood.

Nearly every woman who is subjected to a mutilating operation gives a history of previous years of ill health. Perhaps she will tell you that she never saw a sick day until the advent of her first child, and since that time she has never seen a well day. Another will tell you that she was a strong, robust girl up to entering womanhood, since which time she has been doctored almost continually. Another, who has passed the menopause, after having suffered and been indifferently treated at long range for years, comes under your



observation. For ten years, at least, she has been troubled with various complex pelvic symptoms, which have recently become so much worse as to alarm herself and friends. She has consulted and treated with several physicians at various times. You examine and discover—YES, ACTUALLY DISCOVER, a large fibroid tumor. Another gives a history of ill health during her child-bearing period, difficult labors, slow recoveries. She has reached and passed the average age for the menopause, but has had for years recurrent hemorrhages, having been treated at such times by various physicians. Finally it comes your turn to be consulted. She has been going down for several months, she tells you, suffering almost constant pain in pelvic region, with a continual discharge which is so annoying and offensive that she is considerably alarmed. You diagnose her troubles as she talks, and examination confirms it. After consulting her friends, perhaps you send her to a hospital for operation, and she never comes out from under the anaesthetic. Or, it may be that she refuses operation, and lives to suffer for several months or even a year, when death comes as a happy relief.

I want to say right here, God bless the surgeon! It may be that he was born to wipe out, or cover up, or perhaps sometimes bury, with one brilliant stroke of his knife, our years of shortcomings and mistakes. If the patient recovers, the surgeon gets the credit, which he has hardly earned and richly deserves. If she dies he bears all the blame, which we should share.

Someone has defined surgery as being "an admission of ignorance or weakness or incompetence on the part of the physician." I believe that many times this is more than half true, and the surgeon must have been born as a protest against such conditions. From the number which are being born every day it would seem that we as general practitioners would better turn over a new leaf in our methods of treatment, or else turn surgeons.

We speak of medicine as being "the art or science of treating diseases; especially by the administration of internal remedies;" and of surgery as being "that branch of medicine which treats diseases, wholly or in part, by manual and operative procedures."

From the union of these two powers, medicine and surgery, or rather, in order to join them and thus bring them into closer relationship, the specialists were born, thus forming an indissoluble trio whose limits are bounded only by the inherent qualifications of the individual specialist representing it, and the yet unexplored



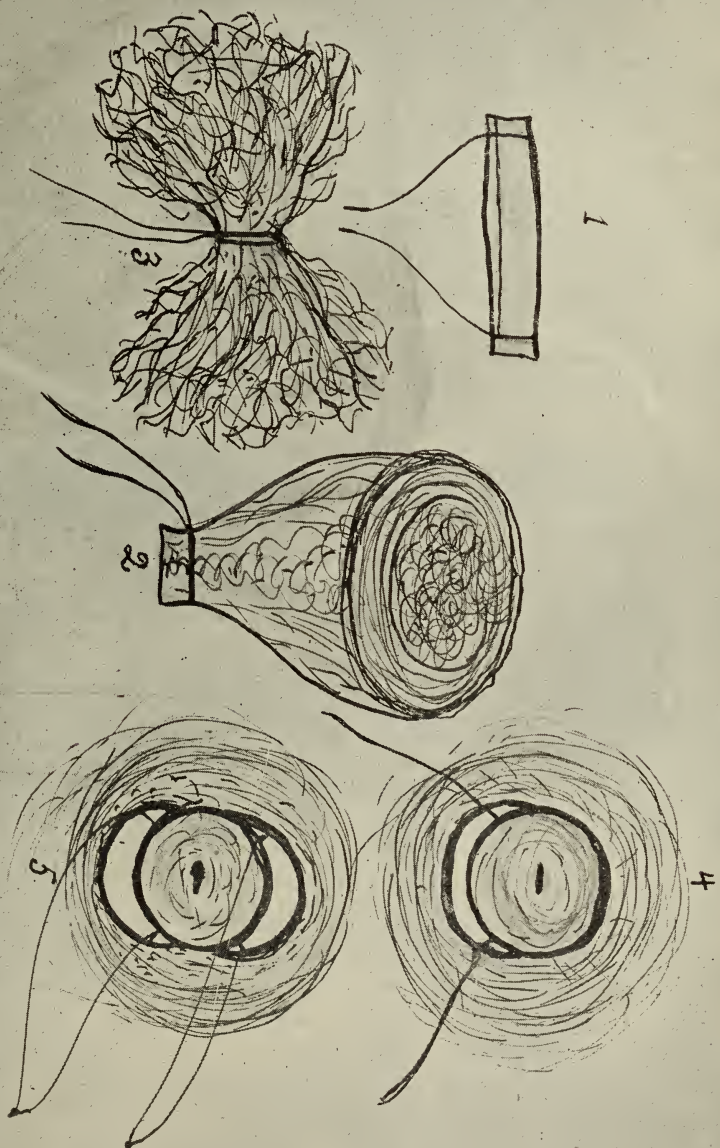


PLATE III.—DR. HARPER.



possibilities and range of his chosen field. The "old family physician" is passing away, with his multitudinous cares and responsibilities. In the light of the present day, with our broader views, we begin to realize the vastness of our field, and each to recognize his own limitations.

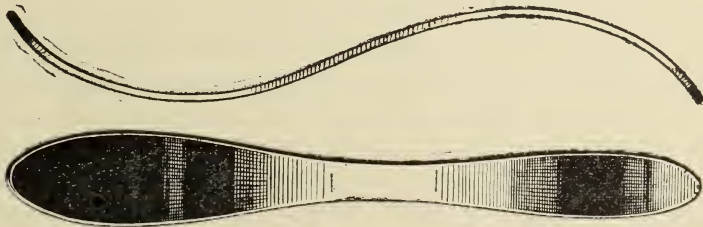
Limiting our practice should not mean that we narrow down, but should be a sign that we are reaching higher up and broadening out, and in thus broadening out we must of necessity eliminate many of the general diseases with which we have to deal in a general practice. If it be our desire to be a general, all-round practitioner, physician and surgeon, no man has a right to challenge us for accepting and treating any case which may come to us, be it medical or surgical, so long as we are properly equipped and capable of handling it. If we choose to treat a certain class of diseases, or even one certain disease, excluding those which we do not wish to follow out, no man has a right to say just how many and what kinds of diseases we are to treat, whether it be one, two or twenty. However, in this day of scientific research and discovery, of refinements in diagnosis and advanced methods of treatment, few men are such mental and physical giants as to be able to long stand the arduous strain which such a necessarily varied practice would bring.

Specialism in its highest and broadest sense means that a man may have a broad general education and experience, and that by process of elimination or exclusion he chooses some line of work in which he aims to do something more than has ever yet been accomplished in that particular line. Specialism is absolutely necessary to advancement, and the greater the number of specialties and specialists, the greater will be the development and advancement, the greater will be the light shed along the line of progress.

As one specialty is developing it opens up avenues of necessity for others. It is not supposed that the over-worked medical practitioner with his varied work, can devote the time and study necessary for specializing to any very great extent in such a field of unexplored possibilities as gynecological work presents; nor can the busy surgeon, with his many responsibilities, do it full justice excepting from a surgical standpoint. Consequently, this leaves a wide gap to be filled in, and by the broad trail of light left by the flaming torch of the surgeon-gynecologist, the medical gynecologist has become a necessity. Unfortunately, this department of medicine

has been held in somewhat light esteem, for the reason that it has been used as a sort of side-line, a specialty by quacks and unprincipled practitioners to cover up their irregular practices.

Probably no department of medicine has made greater progress during the past twenty-five years than the treatment of pelvic diseases of women. Surgical possibilities in this line have been tested and proven to be of incalculable benefit in any conditions; but as in most new moves or advances coming to us in the light of discoveries, many of its votaries have become over-enthusiastic, and finally, over-zealous, in their attempts to bring everything under their domain.



Uterine Repositor, (Harper)  $\frac{1}{2}$  size.

We read much of "radical" and "conservative operations." What seems to be the general interpretation of these opposed terms? "Radical" may mean "unsparing" or "extreme", but in connection with medical and surgical subjects it should never mean "absolute" or "arbitrary" but it appears that it is often so used. Webster says: "Radicalism means root work; the uprooting of all falsehoods and abuses." Then it is to be hoped that we have more "radicalism" practised in both medicine and surgery, more "uprooting of falsehoods and abuses."

A radical cure is one which goes to the root of a disease, without reference to the means whereby the end is attained, whether it be medical or surgical. A cure effected by either one, or by a combination of the two, might properly be termed a radical cure. I cannot help but believe that this term is often misconstrued, misused and abused. Necessarily, measures may sometimes be extreme and unsparing, but they need never be despotic. Radicalism and conservatism are opposed terms, but not in the sense that enemies are opposed to each other. Again, this appears to be the general acceptance of the terms. Briefly; Radicalism represents the motive power, the push, the force that makes things go; conser-

ratism is simply its balance wheel. One serves as whip to drive, the other as checkrein to direct and guide. The two opposing forces combined keep the pendulum ever evenly swinging back and forth between equidistant points. Radicalism, without the restraining influence of conservatism, does not, cannot exist; it then becomes despotism.

When decrying either medical treatment, or arbitrarily opposing surgical measures, we should remember that the science and principles of medicine and surgery are unassailable, the art or application of these principles being entirely dependent upon the character of the individuals representing or applying them. If through individual misconception or misconstruction of these principles, mistakes are made, that does not prove that the principles of either surgery or medicine are all wrong. Men who have conscientiously devoted their lives to the proving of these things are giving us a heritage of which we may be justly proud, and our minds should ever be open to conviction, and our powers of precision in diagnosis should be so cultivated that we may be able to determine with a reasonable degree of certainty whether medical treatment alone is applicable, whether surgical measures alone are called for, or whether a combination of the two will be necessary in order to obtain the best results in any given case.

We are all aware that there are many corrective and curative measures applicable to a much greater number of gynecological cases than surgery could by any system of reasoning claim, just as there are expedients of various kinds in treating an injured limb, short of actual amputation. The therapeutic treatment of pelvic troubles should be on a line with the treatment accorded other organs of the body; general, with a view to overcoming general systemic disturbances; and special, with a view to correcting local conditions.

Such treatment is conservative, in that it saves or preserves; and radical, in that it strikes at the very root or cause. This means broad views, intelligent treatment, against narrow, contracted one-sidedness. I am inclined to think that one of the reasons local treatment has proved of so little benefit in the past is that the doctor has been treating the disease locally only, or, perhaps, generally only, instead of treating both patient and disease both locally and generally. If we will but turn around and begin treating the patient as well as the disease, more satisfactory results will probably be obtained.



In instituting and following out any line of treatment, each expedient used should be directed toward the accomplishment of some definite purpose. Efficacy of treatment is dependent upon the following out of so many details on the part of both physician and patient, that when either one or both are inclined to treat this routine work lightly, it is no wonder that the patient gets discouraged, and even the doctor loses faith in his own treatment.

The crucial test of any method of treatment is the improvement which it brings. This may be so slow sometimes that it is exceedingly difficult to say whether the patient is being benefitted or not, whether she is really gaining ground. But, is she losing? She had been growing progressively and rapidly worse, else she would not have consulted us. If by our efforts we have been enabled to modify or check even to a small degree the downward progress, certainly she is improving. Sometimes it takes a long time to even arrest a disease process and bring it to a standstill; and then comes the long, laborous and oftentimes discouraging climb up hill. This is a most critical and trying period, and requires skill, judgment and tact on the part of the physician, as well as faithful co-operation on the part of the patient. We note changed conditions: then comes decided improvement; finally the patient herself becomes conscious of her own bettered condition; and with this consciousness is born a hope, and she eagerly and confidently looks forward to the day when the realization of this hope will become a certainty.

The most supreme satisfaction that comes to the physician is the consciousness that the results of his treatment have been all that he could have anticipated, and even more than the patient herself ever dared hope for; and the most convincing and telling advertisement is that which comes spontaneously from the lips of a grateful patient.

Many people seem to have imbibed the erroneous idea that a medical adviser, or "family physician," as they may choose to call him, is one upon whom they can rely in case of need for gratuitous advice regarding various "family" affairs; one who will shoulder the responsibility and take the risk of hanging a perfectly normal and physiological process to a most abnormal one, and then we all wonder why so many weaklings, idiots, monstrosities and criminals are brought into the world each year to revert as a charge upon the state. Abortion should be recognized, treated and punished as any other crime of like gravity.



What seems to us the best solution of the problem? The physician, in his close relationship with the family affairs, occupies a most unique position, and offers the best solution, it seems to me, of such a state of affairs. If he be of strong moral character, and truly realizes the responsibilities of his profession, and meets them honestly, and earnestly endeavors to educate and uplift those with whom he comes in such close daily contact, his power for good in the upbuilding of the human race is beyond computation. If, on the other hand, he be of less stable character, negligent of such duties, inclined toward the opposite extreme, and is led sometimes to pervert the object of his high calling, great also will be his influence for evil.

The medical profession, above all others, should require clean, pure, strictly upright men and women; for in no other profession does the individual character of the professor wield such a mighty influence for good or evil, and none other than those meeting such requirements should be permitted to enter its domain.

Proper education of youth along sexual lines, which should naturally devolve upon parents, is too often neglected entirely, or tacitly delegated to chance companions. Knowledge comes to them through the perverted ideas of others; they develop perverted views. Is it any wonder that the offspring of such perversions are monstrosities in human form?

Who, better than the physician, is fitted to serve as the missing link in the broken chain of education? It should be remembered that the healthy, well-balanced mind within the normally functioning body of the girl will develop into the healthy, well-balanced wife and mother.

REPOSITION AND PACKING FOR SUPPORT, with especial reference to the correction of retro-deviations. (Illustrated by cuts)

In order to avoid needless and exhaustive details in explanation, I shall confine myself to a consideration of retroflexions only. The cuts shown will explain the method and principles involved better than any verbal description could do.

Plate 1, cuts shown from right to left represent principal stages through which the organ passes, from a normal anteversion to that of extreme retroflexion. Perhaps the first note of warning sound is that which comes when the organ begins to descend or prolapse, with the consequent dragging down and involvement of adjacent structures. The fundus having dropped back, and the cervix being in front of the center of gravity, its long axis is now on a line with

the vaginal outlet, and descent is the most natural sequence.

Now, instead of proper treatment for overcoming the mal position, the patient may be instructed to go to bed and stay there; to lie on the back with hips elevated, and that the parts will go back all right. True enough, cervix retreats, and fundus "goes back" and stays there.

Plate 1 will show the transition. How about the condition, better or worse? Uterus does not come down any more, and patient wonders why she keeps feeling worse instead of better.

Now for the correction of the condition: In treating a deformity or a dislocation (and this is both), certain well-established rules must be carried out, and our rules of surgery are applicable here, first, to reduce the deformity; and next, to immobilize or fix the organ or part. Nature will then be enabled to accomplish the work of repair necessary for overcoming the pathological condition to the extent that mechanical means may be dispensed with. Nature's forces should be strengthened and conserved, and artificial measures should only be used to attain this end.

The uterus is a very mobile organ, having no really fixed position, consequently one very difficult to "splint" satisfactorily.

Reposition for a retroversion is a comparatively simple process; (Plate 1) position for a retroflexion is a somewhat more complicated affair; but the holding of the organ in position after such repositions seems to be the most complicated problem of all, judging in part from the doubts which have been expressed upon this point by those to whom the subject has been broached; and the success of our local treatment hinges upon our ability to hold the organ in position!

Our first step, following back along the line of its development (See plate 1.) is to reduce the retroflexion to a retroversion. (See foot note). This straightens out uterine canal, improves circulation, smooths out nodules and varicosities of fundus, reduces the deformity!

Our next step, which is really a series of steps, both ascending and descending, is to replace and hold organ in correct position. (See plate 1).

Right here is where I felt the need of a suitable instrument to assist in ironing out irregularities and assist in reposition, something which would give a firmer, broader pressure and farther

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Note—Recto-vaginal and recto-abdominal touch are employed,

reach in all directions than the unaided finger. After many ineffectual attempts to procure something suitable for the purpose, and using many makeshifts, the plan of the simple little instrument was worked out, and the only apology I have to offer for it is that "Necessity is the mother of invention." It serves as manipulator and repositor as well, and if properly handled is less liable to do injury to the tissues than the unaided finger.

Cut 6 of plate 2. shows the uterus poised in about normal position, its long axis being at right angles with vaginal outlet, fundus forward and cervix back of the center of gravity. The opposing forces holding it in position, various ligaments and other structures, abdominal pressure, etc., are supposed to be equal, and the organ in a state of equilibrium. Now relax, or add to, or in any way disturb one or more of these opposing forces, and we get a disturbance of equilibrium, a hang in position, which may mean little or much, depending upon the character and gravity of the disturbance arising.

Now, packing for support, or, in fact. treatment of whatever nature, should be used to supplement or fortify nature's weakened or lost forces, and be directed along the same lines, and toward the same end, that of restoring lost equilibrium and regaining correct position and normal condition.

Fig. 3, plate 2 represents the normal mobility of the uterus, with cotton rolls in situ, and showing directing lines of force necessary in returning organ to normal. The anterior fornix is to be utilized for packing until fundus is carried forward and drops in front of center of gravity, when packing is to be shifted to posterior fornix, thus acting as a series of "rests" on an uphill climb, and as checks or "brakes" on a downhill grade.

If a case of such chronicity and gravity as the one indicated by the drawing can be corrected without surgical intervention, what are the possibilities of such a method of treatment in cases of less severe or chronic character; cases which visit the average doctor's office month after month and year after year, vainly seeking for aid, and later on, turning (or being turned) to the surgeon for the hoped for relief?

Using thus such rational and intelligent measures as will supplement nature's weakened powers; following along the line of nature's plan until she gradually and naturally takes the work out of our hands; slowly but surely gaining step by step, are we over-san-



guine in saying that a non-surgical era in the treatment of diseases of women is more than a probability—a possibility?

In concluding, I desire to say that if I have properly interpreted the trend of the times, the index surely points toward radicalism, “the uprooting of all falsehoods and abuses,” and conservatism, “the disposition toward preserving or saving,” and just as surely against despotism, or narrow one-sidedness, in the treatment of diseases of women.

This is a remarkable well-lighted avenue since the surgeon has shown us the way, and opens up an interesting and unlimited field for thought and discussion, and no one with honest purpose, broad views and unbiased mind need hesitate to enter.

#### DISCUSSION.

Dr. Hoxie:—I do not want to pose in any sense as a gynecologist; but, Dr. Harper brought up this matter with me along the early part of this year and asked me to try her instrument in appropriate cases; and, following out her directions as nearly as I could, I must confess that I have been surprised at the results obtained. I think that this little instrument of hers proves a very happy expedient when one wishes to work with a case that needs manipulation. My own theory as to when to use laparotomy and when to use manipulation is this: In chronic cases, our purpose is to produce supports for the uterus and adnexa. If we use a laparotomy and make artificial ligaments and can then teach the patients to maintain their health and especially the health of the pelvic organs, our operation has been worth while. But, that teaching of the patient to maintain health is practically just as hard after a surgical operation, as without one; and, I believe that in many cases if we begin without the surgical operation and teach them to take right baths, wear correct clothing, right shoes, etc., we would get as good results as if we had operated. My own slight experience has led me to believe that there is a greater field for manipulation than many suppose. I know that I am not entirely alone in this. Some of the best men in the city—not necessarily those you hear spoken of as the best gynecologists and surgeons, but the conservative general practitioners who have to deal with many of these cases—are using methods similar to this. Dr. Laning, whom I notice here tonight, has told me that he has had good success in treating cases, even with adhesions, in this manner. Because of its great value, I think the profession owes Dr. Harper considerable gratitude for bringing up this subject in such an able manner; and, should pay considerable attention to the suggestions which she has offered.

Dr. Jones, Lawrence:—I did not suppose that there was any great number of the profession who did not resort to this or similar means in all cases before resorting to what might be termed operative interference. The measures that Dr. Harper recommends are very good. That they are wholly new or unique, I decline to admit. I suppose that the rest of you know



that as well as I do. I know that in discussing such matters in our town, most of the men have said that they have used that or similar measures before resorting to operative procedures. Personally, I have not seen the need of such an instrument, although I do not doubt that it is a good one. My personal experience has been that these cases are not so very difficult to put in position; the difficulty is in keeping them there; and, I seriously doubt whether a case of very firm adhesions can be put in proper place with a repositor of any kind, and stay. I know of a number of cases where the uterus can be brought forward simply by bringing the entire abdominal wall forward. You could not keep it there no matter what packing or repositor you used. If you keep the uterus forward, it is necessarily going to bring the anterior wall of the bowel forward and you have more trouble than you started with. Another point which I wish to mention is the education of girls. The education should begin with the girl's mother. It has not been my fault in having to do with young women who have not known themselves, the fault has been, in nine times out of ten, the fault of the mother. The mother has not said a word to the young woman until she became a woman and she had had to thresh out these things for herself. These things should be referred to the mother or the grandmother, if you can get that far back. I do not, as a rule, recommend operative procedure in retrodeviations—not if they can be handled with a repositor.

Dr. Stacy:—Most retro-displacements go back to the obstetricians. If you do not care to take my word, take Hirst's. It has been particularly brought out in my practice. I have one section in obstetrical work in hospital service. I have found this: Examine your patients two or three weeks after confinement and then is the time when you will find the displacements that can be readily remedied by ordinary means. I do not believe that there is one retro-displacement in a hundred that is not complicated by other conditions, that will require operation. I do not believe that it should be thought about unless you have metritis, with adhesions, or inflammations of the tubes and ovaries. But, in a case where the uterus does not go back easily, or hold back easily; you have pelvic adhesions, which make it imperative that you operate if you are going to have a normal uterus.

Dr. Blasdel:—I enjoyed Dr. Harper's most excellent paper; and, I was glad to hear a woman's side of it: but, I am sorry Dr. Harper thinks so badly of the surgeon. Now, Dr. Harper says in her paper that each effort should be directed toward some definite purpose, to which I heartily agree. If the uterus can be restored to its normal position, when it is in a retro-displaced position, and can be retained there, then this misplacement can be cured. Where it cannot be so maintained in correct position, then the surgeon has his place in the treatment of this condition. I heartily endorse what Dr. Harper says that we should only use surgery as a last resort.

Dr. Langworthy:—I think that we recognize in a general way two classes of displacements: one in which there is a decided mechanical cause, as adhesions; and, another in which there is lack of tone of the organ, or of the whole body. I see the utility of the instrument mentioned in the

latter sort: I cannot, in the other. I want to put in by way of parenthesis that I do not quite understand what the writer means by "surgical methods;" because, it seems to me this method she describes is really a surgical procedure. What I wish most particularly to say is this: There is a kind of packing that we must not lose sight of. The essayist hinted at it. It is normal fat. I have seen, and you can see, cases where there are no adhesions, but which lack tone and lack fat. Teach the woman how to tone up her general health. If you will build up your patient, you can get her well without any instrument to restore the position of the uterus. That uterus will go back to place without so much unnecessary manipulation.

Dr. Hamilton:—Dr. Harper's paper is very interesting. It is a very well written paper, almost classic, but classics are not always true. I do not agree with Dr. Harper in her method of replacing the uterus. If the uterus were like the one illustrated there on the chart, all right. But the uterus is not on a pivot. It is so made that it will fall back. No amount of manipulation can bring that uterus to place. You may pack it anteriorly, you may go in through the rectum, and pack thoroughly, but the uterus as soon as the woman lies down, or sits down backward—(much laughter and applause) the packing slips out of place and the uterus goes back. I do not believe that packing with cotton is a good method; because the cotton when packed in the vagina becomes as hard as a rock. If I ever pack, I use lamb's wool; but I do not pack for that condition. I think it is useless. The more I see of this condition and the more I study it, the more I become certain that correction by manipulation and packing is impossible.

Dr. Shaw:—I must say, Mr. Chairman, and Fellow-practitioners, that I enjoyed this paper very much. I believe that the amplitude of the swing of the pendulum in gynecology is getting greater all the time. We have come to the time when we are going to study therapeutics more than we do surgery. I am a thorough believer in surgery; but, I believe that it is being overdone. There is not enough prominence given to therapeutics. In this college there are thirty surgeons; how many therapeutics? Not over half the number. If I am wrong, correct me. This ought not to be the case. I cannot agree with the last speaker on retro-deviations. I believe that the great cause of retro-deviations is unscientific treatment of women at parturition. After I have waited on a woman, I say to her: You may take any position in bed that you wish; back, part of the time; face, part of the time; and, side most of the time. Heretofore, women have lain entirely on the back. This produces a varicosity, similar to the varicosity in the scrotum in the male. This varicosity becomes heavy, and it remains. I believe, however, that unless you have adhesions (and they have to be firm adhesions, too,) that most of these cases can not only be benefitted, but cured, by proper treatment. I also believe with the former speaker, that you cannot treat a gynecological case thoroughly and successfully, unless you give it general treatment. All who have come to me have needed systematic treatment. They are generally run-down, constipated, and many of them anemic. This all demands constitutional treatment. I believe in packing. I do not believe in all cotton or all wool. The cotton

is too solid, the wool too expansive. They can be used very nicely together. I want to compliment the writer on her paper; and, coming from a woman, we, as men, should give it greater consideration.

Dr. Johnson:—I want to say a word or two on the cause of retro deviations: I have seen many cases of retro-deviation where the woman has never been pregnant; consequently, the cause cannot be entirely unscientific treatment after parturition. Another thing I wish to speak about is this thing of packing. It is a very difficult matter, almost an impossible thing to pack so it will stay for any time. We usually have such a small space to pack in the vagina, and the packing is so apt to become misplaced. I have tried it a good many times, going through the process very carefully. I have packed as hard as possible—almost hard enough to give some pain—but still I have not been able to hold it in place. I have found it practically impossible. Anything that will tone up the round ligaments and cause them to do their proper work is what we can depend on. Failing in this, we then have to resort to some other means. This usually means surgery. In the particular class of cases which the doctor in her paper means to illustrate, the outline of treatment is quite correct.

Dr. Reynolds:—I enjoyed the doctor's paper very much. While I do not think many of us can adapt it to our use, still it is full of good thought. In regard to the packing: While I admit that we have only a very little space to go on; and, while a great many times the packing does not serve the purpose that we expect of it, it does serve one purpose. If we remember the general directions of the rectum at that point, we know that it is directed from before backward; that the fundus of the uterus lies back against the rectum—its own weight displaces it. By packing in front, we might displace the centre of gravity; inasmuch as we carry it back where the fundus will by its own weight aid in the direction of recovery. Another point to be mentioned is, that a careful examination will reveal that an impaired perineum is responsible in many cases. The perineum not being repaired permits the cervix to fall and the fundus to follow until it assumes the general direction of the outlet; and then, topples backward. I think that great care should be exercised in repairing these cases; I think if we were to give more care to the perineum in the lying-in period, we would overcome or avoid many of these cases.

Dr. Stemen:—I just wish to say a word or two on the preliminary treatment for these manipulations. In all of these displacements you have a congested organ; and, in order to succeed in replacement, you want to give a good cathartic, keep your patient quiet for two or three days, and you will be more successful than if you try to do the manipulation without any preparation.

Dr. Best:—You doubtless remember Carlyle's remark that he never found any peace after he found out he had that diabolical thing called the stomach. I think the same thing may be said of woman and the uterus. You once get a woman's mind turned on the subject—get her to thinking that her womb is out of place—and she will never have any more peace as long as she lives. Of all the diabolical atrocities that have been committed



in the name of surgery, the worst have been committed on women for womb trouble. I remember the case of one woman who had borne several children. She got it into her head that she had womb trouble. She had an operation performed. After a time she became pregnant; and, at the time of delivery, they tried for twenty-four hours to deliver that woman, and they could not do it. The womb was tipped over forward, and it was absolutely impossible to deliver the child. Now, it seems to me that instead of so much work and time being spent on these troubles, we should teach how to prevent these troubles. We have all seen these things. Instead of talking so much about them, let us talk about prophylaxis. Let us teach them not to wear corsets; to dress properly. A woman wears a tight corset; takes a long walk, or does something that strains her vital organs, dancing or something of that sort; and, as a result she has displacement of the womb. I do not believe that anything will ever bring it back but having a baby. That will bring it to its place.

Dr. Cheney:—There is one thing I wish to touch upon: You have all discussed the paper and discussed it pretty freely, but none of you have mentioned the use of the pessary as a support for the uterus. It is a very simple mechanical contrivance that will do away with a whole lot of this "monkey business;" and, will hold the uterus in place.

Dr. Bacon:—I imagine that a great many uterine troubles are imaginary. I also suspect that it is very gratifying to a great many doctors that this is so. I also suspect that if the women used Christian Science they would get along just as well. I think a great deal that has been said to-night is very much of a humbug. I have never succeeded in keeping the womb in correct position after placing it there. You cannot pack every day in the week. I think surgery is the best thing. I am not quick to recommend surgery. Too much of that has been done; but, if surgery is the remedy, it is our duty to recommend surgery. As to the ill effects of a corset, which the doctor speaks of—I think he knows nothing at all about it. I believe that a well fitted corset does no woman any injury; and I recommend my women patients to wear a good corset. Get a good one that fits well even if it does cost the husband a good big sum of money!

Dr. Harper:—It is certainly very gratifying to hear these remarks. I am sorry that Dr. Blasdel has misconstrued my meaning. I do not condemn the surgeon. Why, I think he is the greatest benefactor of the human race. He is the one who has shown us how to do something worth while. Dr. Langworthy spoke of the unnecessary manipulation, etc., and said that we should teach the women how to tone up her general health. How are you going to teach her unless you treat her? I always endeavor to make my treatments a sort of teaching period. By the time a patient has gone through a course of treatment she has learned the value of taking care of herself. Someone objects to the packing described as being too firm. That is the very reason that in certain cases I use the cotton roll—it acts as a sort of soft pessary. If properly placed it should give no discomfort whatever. I use a small cotton roll tied at either end with a string, so that after placing it, you can make traction on one or the other



to arrange roll in place. This particular tampon is simply used for support. I also use others for medication as well as gentler support. (See plate III). Each case must necessarily be a law unto itself, and that sort of packing must be selected to suit each. One will bear the hard roll—another will only require the softest lamb's wool—another will need the combined cotton and wool—depending altogether upon conditions. Several have spoken of the difficulty experienced in retaining packing in place, and of the small space for packing. Where we have the long cervix to manipulate, it is very simple, but the short cervix gives more trouble in retaining packing; however, this difficulty may be easily overcome by modifying the character of the packing. I have no difficulty whatever in retaining packing in place, and have had it stay in perfect position for a whole week, but rarely is such needed. The vagina should never be packed full and tight, unless to control hemorrhage. Packing should never be so hard or tight as to give the least pain or discomfort from pressure upon bladder or rectum, but instead should give a feeling of lightness, support and relief. Several have voiced a doubt as to one's ability to hold the organ in place, even after reposition. You certainly never will succeed until you use the proper method of packing for support. Simply "plugging" is worse than none at all, and only acts as an irritation, giving pain and discomfort. It was mentioned that this method of manipulation was a surgical procedure. It is a mechanical measure which might be called both surgical and medical, or rather a sort of intermediate link between medicine and surgery. In regard to preparation of patient for a first examination, my invariable rule is to make a slight preliminary examination, and then send the patient home for preparation. Lower bowel and bladder should be empty before manipulations are made. Then if a tumor is found we are reasonably certain that it is neither a full bladder nor a loaded rectum. I think that very frequently the reason that treatments are so ineffective and packing does not retain firmly in place is due to neglect of these little details; the first bowel or bladder action displaces tampon. In regard to perineal lacerations, etc., those are purely surgical cases, and no manipulation or packing can be of any permanent service until the floor is repaired. We must have a foundation upon which to build. In all such cases local treatment is of no use, excepting to allay inflammation and prepare for the necessary surgical measures.

## POST-OPERATIVE TREATMENT OF LAPAROTOMIES.

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By R. A. STEWART, M. D., and H. H. HEYLMUN, M. D., Hutchinson

The surgical procedure is definitely in mind in almost every operation, and is changed to meet the necessity of the case and then only to adopt an equally difficult procedure. But the varying phases that can and do arise in the post-operative treatment of laparotomies defy a routine treatment.

In order to facilitate an outline of treatment it is necessary to make something of a classification of cases and it will be found that the following will answer the purposes of this paper in their order of frequency:

1st, Non-Septic.

2nd, Septic.

3rd, Accidental.

In the non-septic cases we usually find the following group of symptoms, which will be found to vary within certain limits, depending on the nervous stamina of the patient and character of operation.

Namely, slight increase in pulse beat, varying usually from 10 to 30 per minute. Elevation of temperature within forty-eight hours of from 2 to 2½ degrees, which will recede promptly upon thorough movement of bowel.

Usually patient will suffer some nausea from anesthesia. The cessation of nausea usually coincides exactly with the re-establishment of the bowel function as indicated by the passage of flatus. Fortunately the great majority of all cases are to be found in this class and their treatment resolves itself into simplest possible procedure.

Rest with the head lowered, a hypodermic of morphine if necessary to allay the first sharp pains and to enable the patient to rally from the immediate effects of the operation, will be found of decided benefit, but the conditions should be exceptional that would require its repetition.

Small normal salines per rectum to allay thirst and the withholding of everything by the mouth except occasional sips of hot

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Read at the joint meeting of the County Medical Societies of Southwest Kansas, Hutchinson.

water until there is a complete cessation of nausea.

In this class of cases we have found that during the second day, one or two grains of calomel given in one-fourth grain doses in the smallest possible amount of water and followed within a few hours with a dose of Pulv. Glyceriza Comp. or Epsom Salts, secures a free bowel movement and definitely establishes convalescence.

In the second class of insidious onset of peritonitis oftentimes misleads us as regards the seriousness of the condition, but when within 48 hours an anxious facial expression, dusky, vigilant, vomiting and pain referred to abdomen, a rapid, wiry pulse, with increasing temperature, and while not unbitable, impulsive in their movements regardless of the consequences, it is always positive you have a septic condition to deal with, and here it is we are so fully impressed with the fact that our most dependable therapeutic measure is the technique and diligence displayed in preparation and operation. It is this class of cases that we have found practically hopeless, yet it calls for the most urgent treatment, since we are nearly always in doubt as to the character of the infection and the extent of peritoneal involvement.

To relieve the over distended stomach of its fecal contents, lavage should be instituted which will afford the patient great relief, materially lessen the distress and possibly enable the stomach to absorb some medication. Ice applied to the abdomen, or the hot turpentine stupes in the case of excessive tympany, the use of large turpentine enemata, hypodermics of esserine ealicylate and in case of weakened heart action, proper hypodermic stimulations together with the intravenous injection of normal salt solution will answer every therapeutic indication. The fowler posture in the hope of limiting injection to the lower pelvis should be adopted.

The results following the strictest application of the above rules are far from gratifying and we feel confident the surgeon will ultimately be able to recognize a septic condition sufficiently early to institute the necessary surgical procedure to prevent its extension.

In the third or accidental class we would include the following conditions, namely: Hemorrhage, adhesions, foreign bodies, etc. Hemorrhage is recognized by syncope character and frequency of pulse beat and promptly demands reopening of the abdomen to secure the bleeding point, or if oozing, to control it by proper packing. Under no circumstances do we dare to trust to nature the absorption of an appreciable hemorrhage.

Adhesions are an accident of operation for which the operator is usually entirely blameless. Since the serous covering of the bowel may present such extensive injury that immediate repair is impossible and the necessity of leaving pedacles raw offers a site for attachment that so far has defied the ingenuity of the surgeon.

The use of the caryle membrane is of very doubtful value and greater reliance has come to be placed upon the floating of the bowel in a normal saline solution, together with the early re-establishment of the bowel function.

The leaving of a foreign body in the abdomen, while on the face of it culpable, is an accident to which we are all liable and we can readily appreciate the circumstances under which it might occur and under which it surely will occur unless a system of definite accounting of all instruments and sponges are charged against the assistant and credited only when accounted for at close of operation. By this means the discrepancy will be discovered while the patient is yet on the table with an undisturbed technique and will enable one to promptly recover the object.

—O—

USE ALKALOID—James Burke in The Lancet-Clinic suggests that we meet the constant changes in the pharmacopial strength of remedies by dropping them altogether and prescribing the alkaloids and other active principles which never change—Vermont Medical Monthly

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Lecithol (Armor & Co.) has been added to the list of New and Non-Official Remedies approved by the Council on Pharmacy and Chemistry, which will be published in the Journal February 1.



## THE RATIONAL AND CONSERVATIVE TREATMENT OF UTERINE FLEXIONS.

By FRANK A. CARMICHAEL, M. D.

When do versions and malpositions of the uterine body become pathological? What symptoms do they provoke? What is their influence upon the health of those showing abnormal positions of these organs? How are we to determine that symptoms present are unquestionably due to malpositions? And what measures may we employ to relieve them? Are questions that have received widely different answers in all decades of the history of medicines and have formed the subject of many interesting monograms.

As early as the days of Hippocrates the condition of incarceration of the gravid uterus was recognized and the study of the positions of this organ probably date from this time.

Throughout the long evolutionary period of the development of that branch of medical science known as gynecology, nearly every position which the uterus can assume in the pelvic cavity, excepting prolapse and procedentia, has been exploited as the normal one. Writers of recognized ability, whose views upon other pathological conditions have been in consonance, have differed widely in their opinions as to what constituted the normal position of this organ. Thus from 1838-65 retroversion and retro-position were considered normal by such men as Holstein, Blund, Tiregoff, Claudius and others, and operators of that day claimed the same brilliant results from changing normal anteversion into pathological retro-versions that we claim today for the reverse procedure.

Anteversion and anteflexion were first advocated as normal position by Boulard and Cusca in 1853 and the same view was supported later by Schultz.

Following the achievement of Emmett and Larson Tait in the domain of pelvic surgery a fresh impetus was given to the writings on this subject in which the speculative and hypothetical reigned supreme. The text books of those times were graced with chapters almost monographic in their comprehensiveness in which lengthy and exhaustive details of the dire effects of uterine malpositions upon the nervous and physical forces of womankind were set forth.

Symptoms of backache, leucorrhoea, dysmenorrhoea, haemorrh-

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Read before the Western Kansas Medical Society.

hage, abdominal pain, nervousness, sterility, hysteria, epilepsy, bladder trouble, constipation and a legion of other common symptoms were supposed to be directly attributable to these malpositions.

Almost every type of mechanical device has been employed in changing the axis and position of the uterine body and in maintaining it in what the attendant considered the normal one. The varieties of pessary are almost countless and the number of surgical procedures that have been exploited in performing suspension and fixation and of this too often innocent and unoffending organ, can only be recalled after considerable computative effort. |

Although we are proud to concede to American surgeons the credit of the first progressive advance in the field of pelvic surgery, we are largely indebted to the German clinics for pointing out its limitations, our later experience showing that their views are in consonance with our own findings, and point out the fact that in a large majority of flexions and versions of the non-gravid uterus, unattended by inflammatory manifestations, no symptoms whatever are present. The experience of most American surgeons, whose practice has not been strictly limited to gynecology, is that 90 per cent of cases presenting the physical findings or uterine version or version flexion with a freely movable uterus, present no symptoms. That 75 per cent of cases presenting symptoms of dysmenorrhoea, amenorrhoea, pelvic pain, backache, etc., present organs in the (present accepted) normal positions and that in the remaining 25 per cent the origin of symptoms can frequently be directly traced to other sources than malpositions.

Reflex nervous symptoms, uterine circulatory disturbances, constipation from impingement of the retroverted uterine body on the rectum, or nerve irritation from pressure on the large pelvic nerve trunks, and other early theories have been dissipated by the light of more thorough and recent investigation and their anatomical impossibility thoroughly demonstrated.

The peculiar arrangement of the uterine supports, granting as they do, a wide range of mobility to this suspended organ make it possible for it to assume almost any position in the pelvic cavity, except prolapse without producing any symptom, so long as the circulation through the broad ligaments is not impeded and the organ is not restricted by adhesions.

Flexion of the cervical portion of the uterus are never sufficient to cause vascular disturbance of its corpora as the remarkably free

anas tomosis makes this impossible.

The intensely irritable nervous organization of the female is such that the most trifling irritations provoke symptom responses out of all proportion to the causal factor, thus making her a prey to a variety of discomforts, vague as to etiology frequently transient in character and often amendable to psychic treatment alone. This is evidenced by the number of cases of "falling of the womb", and other "female troubles"? cured by osteopaths, magnetic healers and other fakirs of like ilk, even through the agency of Christian Science.

Nothing more strikingly corroborative of the effect of suggestive therapeutics can be advanced, than the success following the multitude of useless and irrational procedures for the relief of these conditions.

Surgeons are being forced to the recognition of the fact that in an unusually large number of cases operated on for symptoms supposed to be due to uterine malpositions, the measure has failed to give the relief expected and the symptoms have not disappeared although the anatomical correction has been satisfactorily accomplished.

A persual of the hospital reports of the leading clinics both at home and abroad show a relative and steady decrease in the number of cases subjected to surgical procedures for so-called simple uterine malpositions excepting prolapse and procidentia.

Operations such as Alexander's that are available only when the uterine body is freely movable, while extremely attractive from a technical standpoint are in a majority of cases uncalled for and productive of good results from a psychic standpoint only, except where beginning evidence of prolapse, or complicating inflammatory conditions demanding a more favorable position for drainage of the uterus are present.

It has taken many long years since Emmett first demonstrated his method of perineal repair, to convince the medical profession that trachelorrhaphy and perineoraphy would not cure uterine prolapse nor relieve the symptoms arising therefrom. Thousands of women were condemned to this routine before enthusiasts could be convinced that it was not all their predecessors had claimed for it. Thousands of women have been needlessly shorn of the power to procreate before conservative surgery of the ovaries gained recognition and thousands of women have been subjected to ventrofixa-



tion and ventrosuspension, round ligament shortening and other measures directed toward altering the axis of the uterine body before the profession began to realize that any position which the non-pregnant uterus might assume in the pelvic cavity except prolapse, might be considered normal providing the organ was freely movable and not adherent to other structures.

Until quite recently, the dragging lumbar pain, gastric and neurasthenic symptoms constituting the subjective symptom complex of floating kidney were considered sufficient indication for its fixation, if found to be mobile. Experience is slowly teaching us that while anchoring the mobile kidney, certainly corrects the anatomical malposition, relief from the principal symptom in a large per cent of cases is not obtained, and at the present time many of the most noted operators in this and other countries perform renal fixation as a single operation but rarely except in cases where the crises of dietle are frequent and marked. In the text books of fifteen and even ten years ago, the pathological classification of the different forms of endometritis constituted in itself a good sized volume. These classifications, based upon theory mostly, and elaborately described with reference to their histopathology were made and championed by men in the forefront of the profession, scientific workers of undoubted ability, and their existence dare not be questioned by the profession at large. The meetings of the national, state and county societies alike were burdened by a surplus of papers relative to this condition, as mythical and absurd as some of the hairsplitting classifications and as little understood, but he who closely follows the current literature of the present day will find very little in it concerning endometritis.

Does such a thing as true endometritis exist? At first this would seem a useless question. Inflammation of the uterine mucose undoubtedly does exist, but certainly cannot exist in the multiplicity of forms and stages classified in the majority of text books. The exciting causes operating in its causation, the peculiarities of vascular and lymphatic supply are such that inflammatory processes perhaps originating in the endometrium are never confined to this structure alone but are concomitant with metritis and perimetritis, tubal or ovarian involvement, to which latter conditions the majority of serious and painful symptoms are due.

It is a well known fact that in flexions of long standing or in those that have been accompanied by inflammatory conditions more



or less chronic, certain changes take place at the site of flexure, consisting of infiltration and thickening of the cervical wall at this point. It is undeniable that acute flexions presenting angulation and thickening at the point of flexure may, and sometimes do, produce symptoms of dysmenorrhoea.

It is equally evident that such measures as the use of a pessary or the insertion of a vaginal tampon or attempts to straighten the canal and correct the deformity by the use of tampons directed to pushing the cervix in one direction and the body of the uterus in another are utterly irrational, as the yielding structures within the pelvis on the one hand prevents the application of proper pressure from behind, while the vaginal outlet is possessed of insufficient musculature to properly hold a tampon in front.

While it has been my experience that many cases exhibiting symptoms of backache, dysmenorrhoea and leucorrhoea have been temporarily benefitted by the employment of medicated tampons, I recall no instance where such benefit has been permanent. The pessary may be said to be a relic of medical barbarism and while there are many at the present day among the older school who strenuously uphold its use and advocate its employment, it is steadily falling into disuse and will soon be consigned to the oblivion which it deserves, because:

First: It is mechanical and as a mechanical device, it serves only to palliate and not to cure.

Second: It is unsanitary, unclean and the source of continual annoyance to the wearer.

Third: It must be worn for long periods in order to accomplish anything, and as it rarely does accomplish anything, its employment becomes a matter of habit analogous to the wearing of a suspensory in the male.

Fourth: The insufficient nerve supply of the cervix and vaginal vault make it possible for great damage to be done in the way of ulceration and trauma without much pain being felt by the wearer.

Fifth: It interferes more or less with the normal motility of the structures within the pelvis.

Sixth: The irritation it produces may be a fruitful source in the production of carcinoma.

What then is to be our treatment in reference to the treatment of these conditions? Are we to concur with the statement of our therapeutic brethren, that too much operating is being done? Are

we to contend that many of the cases that are operated would be more certainly benefitted by medical treatment or topical measures? By no means, but we must admit that a great deal of misdirected energy has been spent in cleaving to the old theories and that much to the discredit of surgery has resulted from the selection of an operation unsuited to the case, simply because such operation has presented the routine treatment and because two additional factors must be considered in relation to the operative treatment of these conditions that appeal more or less strongly to the practitioner and gynecologist alike. They are

First: Plastic operations on the perineum and cervix as well as uterine suspensions when performed with the observance of a proper technique and under aseptic conditions are practically devoid of danger, are easily performed, cause little post operative anxiety and are usually without unpleasant sequelae.

Second: The fee for the performance of operations of this type is often a strong incentive to many to perform them when the indication is not clear, or as sometimes happens, when it is altogether absent.

While we may congratulate ourselves that we are living in an age of the greatest advancement in the field of medicine and surgery and that the past twenty years have marked an era in the history of progressive medicine never before equalled, we must still bear in mind that there is much of the old creed and dogma of medicine and surgery that must be eliminated and it is our duty to divest ourselves of every vestige of this and to seek definite and tangible causes for every symptom that the patient may exhibit and to sedulously seek to rule out and exclude that time-worn factor supposed to be so potent in the production of female ills, viz: Disease and abnormalities peculiar to her sex alone, before deciding that they are at fault, for although the possibility of abnormal uterine positions as exciting factors in the production of obscure symptoms may always be entertained, the probability of their being such should not be assumed until all other possible factors may have been rigidly excluded.

The diagnosis of morbid conditions resulting from uterine flexions or flexioversions should not be hurriedly made nor based alone on the subjective symptoms of physical findings. Every physician of experience is thoroughly alive to the variety and decree of pain complained of by different patients exhibiting practically

the same abnormal condition. This may be accounted for by the varying susceptibility to pain, nervous irritability stoicism, or disposition to magnify the symptoms felt by different individuals. On the other hand the presence of a uterine flexion cannot be assumed as an indication for operative correction unless symptoms directly and unquestionably attributable to it are manifest any more than the presence of a tender or prolapsed ovary is an indication for its removal or suspension, or the presence of tenderness over the appendix for the excision of this organ in all cases.

A diagnosis in these cases therefore should comprehend not only a careful physical diagnosis with due and careful consideration of all subjective symptoms but the psychic and temperamental status of the patient should be the subject of the careful study their importance merits. If this were done and conscientiously done in all cases, the number of surgical neurasthenics would be reduced to the minimum.

Given a careful and correct diagnosis, the basis of conservative treatment in these cases, is to select the measure calculated to most certainly and speedily affect a cure of the condition, and comprehends not only the foresight to abstain from surgical measures that are inadequate or that do not promise to permanently cure the conditions, but where the morbid process is such as to warrant such interference it should be fearlessly urged.

Indiscriminate operating in these cases should be discouraged because it reflects discredit on the surgeon and surgical methods in general, especially in localities where there exists a natural prejudice.

The surgeon should not be influenced to operate in these conditions because the operation is one that is easily performed and might help the patient, because there is but slight risk to the patient, because he wishes to perfect his technique or establish a reputation as a successful (?) operator (as some deem every operation to which the patient does succumb as a "successful" operation regardless of the fact that the patient's condition may not be improved), or because the few would materially swell his bank account, but should be actuated by a sincere desire to do what is best to relieve the suffering of the patient, regardless of motives of personal gain or aggrandizement.

It is my belief that cases of uterine flexion and version when

demanding treatment at all, whether from the presence of adhesions that interfere with the mobility of the organ or complicating metritis or perimetritis are amendable to surgical treatment only, if a cure is to be expected.

Medication and the application of mechanical devices for the permanent cure of these conditions belong to a period as remote from the present age of enlightenment as the sorceries and incantations of the ancients.

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Grocco's Triangle in Exudative Pleurisy.——Padoa (Gaz. d. Osped 1907, No. 23).—It will be remembered that in 1902 Grocco and, somewhat later Koranyi called attention to a triangular area of dullness occurring in cases of pleuritic effusion, along the spinal column on the healthy side. The most rational explanation of this phenomenon consists in the assumption that the effusion pushes mediastinum away so that it comes, at least in part, to lie on the other side of the spinal column. Clinicians who claim to have observed this sign in pneumonia were apparently led astray by a simultaneous but overpleuritic effusion. Interesting observations have been made in double pleurisies in which Grocco's Triangle shifts from one side to the other in proportion as one or the other effusion attains the higher level.

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The only evidence of an acute intussusception may be the passage of a small amount of blood per rectum. One should always make a thorough rectal examination as even an intussusception high up in the small intestine may sometimes be felt per rectum.



# THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

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CHAS. S. HUFFMAN, . . . . . EDITOR

J. E. SAWTELL, }  
GEO. H. HOXIE, } ASSOCIATE EDITORS

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Subscription rates: \$2.00 per year; 20c single copy. Advertising rates furnished promptly on application.

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**Meeting of State Society.** The Kansas Medical Society will meet at Iola May 6, 7, and 8, 1908.

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Dues for the year 1908 should be paid at once, so that all members may receive their 1908 membership card.

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Dr. O. P. Davis, councilor for the Fifth District, was present at the meeting of the council Dec. 27, 1907, at Kansas City. Inadvertantly his name was omitted in the published report in the January issue of the Journal.

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**Amendment to Medical Act.** It has been known since the enactment of the law of 1901, governing the practice of medicine that it did not reach all classes of irregular practitioners now doing business in our state. There are many under the guise of magnetic healers, who do not pay any license fee, who have no authority whatever to practice medicine, but by advertising in the local newspapers, that they can cure anything from a chilblain to a cancer, that they do not use drugs of any kind, but by exercising some occult power handed down to them by their great grandfather, they are able to do these miracles. By this method they take thousands of dollars from a credulous public and bring the profession of medicine to a lower standard in the eyes of the people. At the special session of the legislature which convened Jan. 16, 1908, an amendment to section 6 of chapter 254 of the laws of 1901 was passed, and received the signature of the governor.

This section is given below, with the amendment enclosed in brackets:

Section 6. Any person shall be regarded as practicing medicine and surgery within the meaning of this act who shall prescribe, or who shall recommend for a fee, for like use, any drug or medicine, or perform any sur-

gical operation of whatsoever nature, for the cure or relief of any wounds, fracture or bodily injury, infirmity or disease of another person, or who shall use the words or letters, "Dl.," "doctor," "M. D." or any other title in connection with his name which in any way represents him as engaged in the practice of medicine or surgery, (or any person attempting to treat the sick or others afflicted with bodily or mental infirmities, or any person representing or advertising himself by any means or through any medium whatsoever, or in any manner whatsoever, so as to indicate he is authorized to or does practice medicine or surgery in this state, or that he is authorized to or does treat the sick or others afflicted with bodily infirmities), but nothing in this act shall be construed as interfering with any religious beliefs in the treatment of diseases, provided that quarantine regulations relating to contagious diseases are not infringed upon. All persons who practice osteopathy shall be registered and licensed as doctors of osteopathy, as hereinbefore provided, but they shall not administer drugs or medicine of any kind nor perform operations in surgery.

This act shall not apply to any commissioned medical officer of the United States army, navy or marine service in the discharge of his official duties; nor to any legally qualified dentist, when engaged in the legitimate practice of his profession; nor to any physician or surgeon who is called from another state or territory in consultation with a licensed physician of this state, or to treat a particular case in conjunction with a licensed practitioner of this state, and who does not otherwise practice in the state. Nor shall anything in this act apply to the administration of domestic medicines, nor to prohibit gratuitous services; provided, any person holding a diploma issued by an optical college, and who has studied the anatomy of the eye and contiguous parts, human physiology and natural philosophy for at least six months under a competent teacher, and who shall pass examination satisfactory to the State Board of Medicine Registration and Examination, shall be eligible to register as an optician or doctor of optics, and shall be otherwise governed by this act so far as the same is applicable.

It is sincerely hoped by the authors of this amendment that it will prohibit all kinds of irregular practice and compel every one who desires to practice medicine in Kansas, to take the examination before the proper board, and if qualified, he will be given a certificate. Under this act it is not necessary to prove treatment of a case or collection of a fee, the mere act of advertising constitutes an offense.

The passage of this amendment demonstrates what can be done by organization. When it was known that a special session of the legislature was to be called, the secretary of the state society wrote to the secretary of each county society, giving a synopsis of the proposed amendment, and asked them to take the matter up with the members of the county society, and also see their state senator and representative, explaining to them the nature of the

proposed law, and request them to support it. The secretaries of the different county societies did their duty well, for when the legislature convened, every member seemed to know about the proposed legislation and voted for the amendment. Would suggest that the legislative committee follow this plan, with any proposed legislation to be presented at the regular session next winter.

The following is from Surgeon General Rixey of the Navy in response to the resolutions adopted at the meeting of the Council in Kansas City Dec. 27 1907:

Dear Sir: I am in receipt of your letter of January 10th, enclosing a copy of the resolutions offered at the meeting of the Council of the Kansas Medical Society, December 2, by Doctor E. J. Lutz.

Permit me to express my deep appreciation of the spirit which prompted Doctor Lutz in this matter and of the unanimous manner with which his colleagues in the Society endorsed the sentiment expressed.

With feelings of gratitude, believe me, Very truly yours,  
R. M. Rixey, Surgeon General, U. S. Navy.

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**SOCIETY NOTES.**

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**Decatur and Norton County Medical Society.**

Your presence requested at H. O. Hardesty's office, Jennings, Kansas, 2 p. m. Wednesday, February 12, 1908.

**PROGRAM.**

Pneumonia, R. H. Smith.

Paper, S. C. Standard.

Paper, E. L. Davis.

Clinic, H. O. Hardesty.

Round Table Discussion, General.

C. G. Brethouwer, President,

C. S. Kenney, Secretary.

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**Missouri Valley Medical Society.**

Twentieth Semi-Annual Meeting of the Medical Society of The Missouri Valley, Lincoln, March 19-20, 1908.

**OFFICERS.**

W. F. Milroy, M. D., President, Omaha.

C. B. Hardin, M. D., Vice-President, Kansas City.

A. E. King, M. D., 2nd Vice-President, Blockton, Ia.

H. B. Jennings, M. D., Treasurer, Council Bluffs.

Chas. Wood Fassett, M. D., Secretary, St. Joseph.

Arrangement Committee, A. D. Wilkinson, H. W. Orr, H. J. Lehnhoff.

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Editor Journal:—Owing to the illness of our president, Dr. J. P. Scoles, the January meeting of the Cherokee County Medical Society was held at his residence. Dr. J. H. Boswell of Baxter Springs, read an excellent paper on "The Valvular Lesions of the Heart," and exhibited a specimen secured from a recent autopsy. Dr. H. H. Brookhart reported a case of Hepatic Carcinoma. At the close of the session Dr. Scoles served the members an elegant luncheon, and was given a hearty vote of thanks.

R. C. Lowdermilk, Secretary.

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**Chautauqua County Medical Society.**

In proportion to the population, Chautauqua county will probably carry off the honors in the percent of number of doctors who are members of the county organization, and much credit is due their efficient secretary for this splendid organization. The following report was sent under date of February 4.—Ed.

Editor Journal:—On looking over the last State Journal I was somewhat surprised to see no mention made of our society whatever. At the beginning of the year 1907 there were about twenty-two doctors in the county, all told. Of those, four doctors have moved away, one very old doctor died. During the year eighteen doctors joined the society, three of whom were made honorary members. Two members have moved away. Every doctor in the county excepting two now belong and every member had paid his dues for the coming year excepting one. There has been \$106 paid into the society treasury during the year. The doctors are very widely scattered and conditions could not be much worse to get a meeting. Yet we have had nine good meetings. There has been ten splendid papers read. As the society was young, the doctors have spent much of their time at these meetings discussing the best methods of perfecting our organization. This society is seeing that the medical law is observed here. Yesterday, February 3, was the first anniversary of our society's existence. We just had a quorum, and it was the liveliest quorum you ever saw, too. Dr. G. W. Goss read a paper on "The Objects of Medical Societies." The paper was ably reviewed by Dr. Garrison. This society is keeping in touch with the state board of registration and examination. We are having some use for that board at present.

Milton T. Evans, Corresponding Secretary.

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**Montgomery County Medical Society.**

Executive Committee: H. M. Casebeer, President.

Geo. M. Seacat, 1st Vice-President,

W. C. Chaney, Secretary.

All meetings held at the Carl Leon Hotel, Independence, Kans.,

3 p. m.

**PROGRAM.**

February 12, 1908.

J. A. Pinkston, Independence. J. T. Davis, (Sciatica) Independence,

- P. H. Dalby, Havana. J. N. Strawn, Elk City.  
March 10
- J. H. Johnson, Coffeyville. A. W. Evans, Independence.  
W. F. Bluett, Caney. J. F. Gard, Cherryvale.
- April 4.
- W. C. Hall, Coffeyville J. S. Scott, Independence.  
M. J. Williams, Liberty. W. P. Booker, Caney.
- May, State Medical Society Meets at Iola May 6, 7, 8,  
June 9.
- F. A. Stevens, Caney. D. W. Howell, Havana.  
A. A. Krugg, Coffeyville.  
Report of delegates to State meeting.  
July 14.
- M. A. Finley, Cherryvale. F. B. Taggart, Independence.  
W. E. Curd, Copan, Okla. C. I. Crandell, Caney.
- August 11.
- Mary S. Martin, Coffeyville. Mamie J. Tanquary, Independence.  
Ida M. Scott, Independence.
- September 8.
- J. G. Biglow Caney. E. A. Miner, Independence.  
W. E. Youngs, Cherryvale. W. S. Hudiburg, Independence.
- October 13.
- J. R. Scott, Independence. J. A. Rader, Caney.  
C. H. Fortner, Coffeyville. J. E. Dwyer, Independence.
- November 10.
- Geo. M. Seacat, Cherryvale. E. C. Wickersham, Independence.  
J. F. Blank, Elk City. Geo. W. Brown, Coffeyville.
- December 8.
- Election of officers for 1909. Banquet. Special program.  
January 12, 1909.
- Address by President. C. E. Grisby, Coffeyville.  
J. N. Davis, LeHunt. L. A. Jacobus, Coffeyville.
- Officers of the society for 1908.
- H. M. Casebeer, Independence, President.  
Geo. M. Seacat, Cherryvale, 1st Vice-President.  
I. B. Chadwick, Tyro, 2nd Vice-President.  
G. J. Biglow, Caney, 3d Vice-President.  
Mary S. Martin, Coffeyville, 4th Vice-President.  
W. C. Chaney, Independence, Secretary.  
W. E. Youngs, Cherryvale, Treasurer.

I. B. Chadwick, C. C Surber, Delegates to State Society.

I. B. Chadwick, W C Hill, E C Wickersham, Board of Censors.

Please notify the secretary what your subject will be, and in case no report is received by the February meeting a subject will be assigned those failing to report.

In case you cannot be present at the meeting at which your name appears on the program, please send your article to the secretary in time for the meeting, that the members present be not disappointed in being entertained by an article on some live topic.

Any member having an interesting clinical case is requested to bring it before the society at any meeting.

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### **Doniphan County Society.**

The Doniphan County Medical Society passed the following resolutions at the quarterly meeting held in Severance, Kansas, Jan. 7, 1908:

Resolved, That the members of the Doniphan County Medical Society will refuse to support any man for governor who will not agree to appoint as members of the State Board of Health and the State Board of Medical Examination and Registration physicians recommended and endorsed by the different state Medical Societies of Kansas.

Resolved, That the Doniphan County Medical Society endorse Edward Bok Editor The Ladies Home Journal in his fight against patent medicines, and quackery, and that we extend to him our entire support.

H G Herring, Secretary

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### **Shawnee County Society.**

Editor Journal:—At the last meeting of the Shawnee County Medical Society the following resolutions were passed unanimously:

Whereas, The functions of the medical department, both in the army and navy, differ as widely from those of other departments as the saving of life differs from its destruction, and

Whereas, common sense, observation and experience alike teach that the preservation and cure of disease should be under the direction and control of those who understand the laws of health and disease, and

Whereas, in the pending issue between Surgeon General Rixey and Admiral Brownson of the Bureau of Navigation we believe the

best interests of the navy and nation lies in sustaining the former.

Be it resolved that this society approves the statement of President Roosevelt of the 2nd inst., to secretary of navy, that hospital ships should be treated as floating hospitals and therefore placed under the command of a medical officer, the navigation being controlled by a competent sailing master, and that it fully endorses and approves the contention of Surgeon General Rixey.

These resolutions were introduced by Dr. W. L. Schenk of Topeka, and met with unanimous approval.

Dr. C. F. Meninger read a most excellent paper on "Dietotherapy of Acute Fevers."  
J. B. Tower, Secretary.

### **Crawford County Society.**

Pittsburg, Kas., Jan. 6, 1908.

Editor Journal:—The Crawford County Medical Society met at the study of the Christian church Monday evening, Jan. 6, and was called to order by the president. No meeting having been held last month, this was considered "the annual meeting for the election of officers for the ensuing year."

Minutes of last meeting read and approved. The retiring president, Dr. H. B. Caffey, presented a very interesting and pertinent paper bearing upon the needs, possibilities, responsibilities and accomplishments of the County Medical Society, which furnished food for thought and discussion. Dr. Bogle remarked one very evident accomplishment of the society during the past year, and that was the conspicuous absence in the lay press of all mention of attendance upon cases of illness, accident, operations, etc., by members of the society. Dr. Bogle also recommended that the medical society take some active measures toward having an "anti-spitting" ordinance passed and enforced by the city council; and also that an inspector be appointed in the interest of the public health to regularly inspect all dairy products placed upon the market. Dr. Chapin introduced the subject of vital statistics, and thought there should be some regulations made whereby midwives and so-called "nurses" officiating in cases of birth, without an attending physician, should be obliged to report all such cases to the county health officer.

Following is result of election of officers for ensuing year:

President, Dr. H. H. Bogle, Pittsburg; Vice-President, Dr. Chas. Chapin, Frontenac, Secretary-Treasurer, Dr. Amelia A. Dickinson, Pittsburg; Dr. A. M. Smith was appointed to serve out the



unexpired term of one year on Board of Censors, of Dr. E. O. Sloan. Dr. H. L. Stelle was elected to serve on Board of Censors for three years, succeeding Dr. Wm. Williams, the retiring member. Motion to adjourn carried.

Francis A. Harper, Secretary.

### **Mitchell County Society.**

Editor Journal:—The Mitchell County Medical Society held its regular Annual meeting in the Woodman hall, Beloit, Kan., December 9. Members in attendane, Dr. Bohrst, Spessard and Valette, of Glen Elder; Drs. Home, Brewer, Lobdell, Cook, Daily and Daniels, of Beloit.

Paper read by Dr. Daily on Ectopic Gestation, was very fully discussed. Paper by Dr. Daniels on Abortion was postponed until March meeting, owing to the lateness of the hour.

Officers elected for the year 1908: Dr. E. E. Brewer, president; Dr. M. R. Bohrst, vice-president; Dr. W. H. Cook, secretary, Dr. F. M. Daily, member board of censors.

After election of officers all the doctors, with their wives met at the home of Dr. and Mrs. E. N. Daniels, and enjoyed a banquet, such as the Beloit physicians' wives have been tendering each annual meeting to the members of the Mitchell County Medical Society. This annual feast is looked forward to with much pleasure as it not only brings the physicians in closer touch with each other, but likewise incurs the friendship and good fellowship that should preavail between their families.

It is needless to say that the Mitchell County Medical Society is much alive and wide awake, for "actions speak louder than words."

With this you will please find check for \$32 in full payment of the annual dues for the year 1908, for sixteen members who compose the Mitchell County Medical Society, as follows: Drs. E. E. Brewer, Beloit; F. B. Home, Beloit; W. H. Cook, Beloit; F. M. Daily, Beloit; D. S. O'Brien, Beloit; M. J. Lobdell, Beloit; E. N. Daniels Beloit; M. R. Spessard, Glen Elder; H. B. Vallette, Glen Elder; M. R. Bohrst, Glen Elder; S. T. Blodis, Scottsville; E. G. Mason, Cawker City; M. J. Saunders, Cawker City; J. F. Ullman, Simpson; K. P. Mason, Cawker City; H. L. Ratliff, Cawker City.

Since the reorganization of the Mitchell County Medical Society, we have never lost a member by lapse or failure to comply with the laws and pay dues. Two members removed from the

county during the past year.

Yours truly,

E. N. Daniels, M. D., Retiring Secretary.

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## NEWS AND NOTES.

### Spokane County Medical Profession, Washington.

Seventy-five members of the profession, representing all the cities and towns in Spokane county, were entertained at a banquet by the Spokane County Medical Society in the Hall of the Doges at Davenport's restaurant, Spokane, Wash., the evening of Jan. 8, in honor of the Washington state board of medical examiners at the close of the semi-annual examination of applicants for licenses to practice in the Evergreen state. Dr. N. Fred Essing of Spokane, was toastmaster, and these responses were made:

Dr. D. Mason, "Early Days of the Profession;" Dr. W. F. Morrison, "The Social Side of a Physician's Life;" Dr. Harry S. Martin, "The Physician as a Business Man;" Dr. E. B. Nelson, "The Country Doctor;" Dr. George K. McDowell, "The Physician Abroad;" Dr. J. G. Cunningham, "Professional Responsibility;" Dr. N. M. Baker, "Duties of a Physician in Preventive Medicine;" Dr. E. D. Olmsted, "The Physician in Politics;" Dr. M. A. W. Shockley, surgeon at Fort Wright military reservation, "The Army;" Dr. T. L. Catterson, "Our Society;" Dr. C. M. Doland, "Our Younger Members;" Dr. C. W. Sharpless, "Our Medical Laws;" Dr. W. Johnson, "Washington State Medical Association," and Dr. W. J. Munley, "Our Wives and Sweethearts."

The committee on arrangements was composed of Dr. T. L. Catterson, Dr. Wilbur W. Mackenzie and Dr. R. I. Newell.

### Missouri's Health Board Elects.

Jefferson City, Jan. 8.—The state board of health held its annual meeting here today and elected officers as follows: Dr. Albert Hammel of Desoto, president; Dr. Ira W. Upshaw, of St. Louis, vice president; and Dr. J. A. Adcock of Warrensburg, secretary. The next meeting of the board will be held in Kansas City May 4, 5, and 6.

Th new board of health in Kansas City, Kansas, held its first meeting yesterday afternoon and elected the following officers: Dr.

C. B. Stemen, president; Dr. Charles Ott, vice-president and D. J. A Fulton, secretary

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### **To Stop Spitting—City Health Officer Urges Action by Council.**

City Physician D. O. Munson of Pittsburg, Kans., called the attention of the city council last night, in a communication, to the filthy conditions of the city's streets, public places and street cars, due to spitting, and urged the council to enact an ordinance to stop spitting.

"The health of our city is endangered", stated Dr. Munson. "Women who have to pass along the streets, with skirts trailing in the filth on the walks are not safe."

The city attorney was instructed to draw up an ordinance and the councilmen seemed to favor the enactment of such an ordinance.

Model ordinances from St. Joe, Joplin, Mo., and Fort Worth, Tex., were submitted to the city attorney.

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### **International Congress on Tuberculosis.**

Active preparations for the International Congress on Tuberculosis to be held in Washington, next September, are under way in other countries. The National Committees for France, Germany, Sweden, Austria, Holland, Greece, Bulgaria, Cuba, Venezuela, Brazil and Costa Rica have organized and have forwarded their membership lists to the Secretary-General. The French committee has a membership of over three hundred and includes men of prominence in public life as well as in the medical profession. The officers of this committee are president, Dr. Louis Landouzy of the medical faculty of the University of Paris; vice-presidents, Dr.—Faisans of the University of Paris, Prof. Vallee the eminent veterinarian, of Alfort, Dr. F. Bezancon of the University of Paris, and Dr. Le Gendre; secretaries,—Dr. Triboulet, Secretary-General of the last International Congress which was held in Paris three years ago, Dr. Nobecourt, Dr. Leon Bernard, Dr. Dehan and Dr. Georges Bourgeois; treasurer, M. Masson.

The secretary of the German Committee, Dr. Johannes Nietner, was secretary-general of the recent International Congress on Hygiene and Demography. Other members of the committee are Dr. Gotthold Pannitz, Secretary-General of the International Tuberculosis Association, Dr. B. Frankel, Dr. Ernest von Leyden, Pro-



fessor of emeritus of the University of Berlin, and Dr. Johannes Orth, Professor of Pathology in the University of Berlin.

Dr. N. P. Tenderloo, of Leyden, another well known pathologist is a member of the committee for Holland. Dr. P. K. Pell, of the University of Amsterdam, is chairman of that committee, and Dr. W. J. von Gorcum of The Hague is the secretary.

Dr. A. Herrera Vegas, the chairman of the Venezuelan committee, is president of the Venezuelan Anti-tuberculosis League, and a member of the National Academy of Medicine at Caracas. Dr. P. Acosta Ortiz, the vice-president, is a director of the hospital at Vargas, and Dr. L. Razetti another member of the committee, is vice-rector of the University of Venezuela, and permanent secretary of the National Academy of Medicine. All of the members of Brazilian committee are actively identified with the anti-tuberculosis movement in that country. The committee includes Dr. J. J. Azevedo Lima, of Rio Janeiro, president of the Brazilian Anti-tuberculosis League; Dr. Oswaldo Cruz, director-general of the Department of Health, Dr. J. J. Seabra and Dr. Cypriano de Freitas, of Rio de Janeiro.

The president of the Cuban Committee is Dr. Guitras formerly professor of pathology in the University of Pennsylvania and now at the University of Havana. Dr. J. L. Jacobsen the vice-president, is president of the Cuban Anti-tuberculosis League. The secretary is Dr. M. G. Lebrede of Havana. Two well known members of this committee are Dr. Aristides Agramonte, the last surviving member of the famous yellow fever commission of the United States army, and Dr. Carlos. Finlay, who was recently awarded the Mary McKinsley medal by the Liverpool Association for the Study of Tropical diseases.

Dr. B. Patrikios, the chairman for the committee for Greece, is secretary of the Department of Health of Greece, and secretary-general of the Greek Red Cross Society. Dr. Aristote Kouzis, the secretary is a professor of the University of Athens. Dr. Constant Savas, a member of the committee is professor of Hygiene in the University of Athens, and is physician to the King of Greece; Dr. P. Manoussos is principal medical director of the military hospital at Athens; Dr. Kalliontzis is professor of surgery and Dr. Pierre J. Rondopoulo is professor of pathology at the University of Athens.

The Hon. Otto von Printzkold, the chairman of the Swedish



committee, is the first chamberlain of the Swedish court. The secretary, Dr. Bertil Buhre, is the president of the great Swedish Anti-tuberculosis League, the largest volunteer association of the kind in existence.

The Costa Rican committee has named Dr. Louis P. Jiminez chairman, and Dr. Theodoro Picado, of San Jose, secretary. Other members are Dr. Theodoro Prestinary, Dr. Benjamin Hernandez and Dr. Marcos Zunegxa, all of San Jose.

Three chairmen have been named by the Austrian committee. They are Prof. Leopold v. Schrotter, of the Medical Faculty of the University of Vienna; Dr. Weichselbaum and Dr. Richard Paltauf, of the Department of pathology of the University of Vienna. The secretaries are Dr. H. v. Schrotter, Dr. L. Teleky and Dr. J. D. Bartel.

Dr M. Rousseff, director of the Department of Health of Sophia, is president of the Bulgarian committee; Dr Ivan Oggianoff, secretary of the Superior Board of Health at Sophia, is secretary and the members include Dr. Georghi Zolotovitch, Dr. Ivn Theororoff, director of the Sontorium for Tuberculosis at Rojan, and Dr. S. A. Valcovith.

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## ABSTRACTS.

### Home Made Reputation.

The home town paper and medical fame.

Here is an item from the Cornville Clarion—you have seen its like a thousand times and, if God has blessed you with a sense of humor, you have smiled at it ten hundred times:

Dr. John G. Bobbins of this city has gone to Europe for a course of medical study under the great European professors. While abroad, Dr. Bobbins will conduct clinics at the hospitals of Germany and Great Britain. He will return home in about three months.

You can see the prints of Bobbins' clumsy fingers on the "local page" of the Clarion, but Bobbins has been made happy and, incidentally, so has Bobbins' wife—who stays at home to care for the children while Bobbins takes his Cook's tour to international fame. Bobbins will send all his pay patients European post-cards bearing pictures of hospitals and medical schools which he, more than likely, sees only from the back seat of a "rubber neck coach." The Berryville Eagle will be found to contain the following item or one like unto it:

Dr. Benjamin Buggs of this city returned to Chicago yesterday where he will continue his medical studies. This is his second year in the department of surgery in which he was looked upon as a most promising young man. Dr Buggs will be remembered as the accomodating assistant of Mr. J. C Hypo, the State Street photographer.

Of course, surgical departments in our larger medical colleges are not in the habit of making surgical assistants of first year students who—in the vernacular of the medical studentdom—are hardly dry behind the ears; but Dr. Bugg (first year students are always Doctor in the village paper) was of course, an exceptional young man. If you do not believe it, loiter with the crowd down at Berryville, when Bugg is home on vacation. Ask him if he knows Dr. Senn and hear his inevitable reply: "Who? Nick? Why sure. He ain't on the faculty at our school, but he picked me out of the bunch at Cook County to help him do an enterostomy." Of course, Senn hasn't done surgery at "Cook County" for many seasons, but if he had, Bugg wouldn't know it. But enough of Bugg. Note this item in the Tiptonville Register:

Dr. Augustus Smiley of this city was called to Omaha Saturday in consultation with a number of prominent physicians in the case of Mrs. Lizzie Buster who is suffering from a large tumor.. Dr. Smiley did not know, at the time of departure, whether he would operate or not.

Now we know that Mrs. Buster is Dr. Smiley's sister-in-law and that he went to Omaha to see if "professional courtesy" could not be stretched another point without breaking, whereby Lizzie would secure free treatment in honor of her kinship to Augustus. but there are ways and ways of going to Omaha and Augustus chose to go in consultation and the town paper gratified his ambition. Just one more from our scrap-book of home-made fame:

Dr Hiram Buckram, our enterprising physician and surgeon, nas just received an electrical outfit and static machine which are being installed in his office by Thomas Buzzer, the electrician. The outfit is identical with that used by the greatest specialists in the big medical centers and Dr. Buckram will use it in his growing practice in gynecology, diseases of men and pediatrics.

It is said that Hiram stopped the editor on the street and took him into the office to see the machine installed, but this comes from the doctor across the way and, hence, is subject to a discount of ninety-four per cent. Looking at these things good-naturedly, we cannot but wonder what a malformed bump of egotism can derive satisfaction from such dribbling twaddle and yet, if we should ask all who have given such information to the local editor at some

time in his life, to hold up both hands - some of you would be compelled to drop this magazine. The writer of these lines may not be entirely guiltless, but he looks back now upon any such transgressions as the puerile acts of another day. Our fat little scrap-book of home-made fame, however, suggests this idea to us. When the American Medical Association gets its post-graduate courses working in the county societies, let's devote a few evenings under the guidance of a sane and judicious advertising man. It will improve the quality of our local newspaper "literature".—G. T. P. in the Chicago Clinic.

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### **Erysipelas—Pneumonia.**

W. E. Strobe, M. D., Martinsville, Ohio.

June 5, 1905 I was called to attend Mr. K—. I found him suffering with a very aggravated case of facial erysipelas. I applied my usual treatment of carbolized salve locally, and gave the proper internal treatment, but when I saw the case again in twenty-four hours I found symptoms no better. I thought I would try Antiphlogistine. After applying the salve to face, I spread Antiphlogistine on a cloth making a mask that would cover the entire face, directing nurse to change when it dried out.

Next day I found patient much improved. He said "that clay relieved all the burning five minutes after you applied it." I now make it a rule to use Antiphlogistine in treating erysipelas, and I am sure my patients get along faster than they did when treated without it.

I also use antiphlogistine in pneumonia, and all cases of inflammation of the lung or pleura. Indeed I would hate to have to treat this kind of cases without Antiphlogistine. I will report on one case of an infant where I believe this remedy saved the patient's life.

January 3, 1906, Infant age 18 months. Two days after initial fever, temp. 104 degrees, resp. 48, pulse 120; tongue coated, could hardly get breath, expiratory moans, crepitant rales. Gave internal treatment, and covered both back and front of chest with Antiphlogistine. In twenty-four hours the breathing was much better and temperature lower. On my third visit I found all the symptoms so improved that I dismissed case.

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### **The Alkaloidal Treatment of Pneumonia.**

In patients with a full bounding pulse and a hot dry skin—asthenic cases—begin treatment with aconitine, veratrine and digitalin (Defervescent Comp. No. 1); or in patients having a small, quick, thready pulse and a hot dry skin—astheniac cases—give aconitin, digitalin and strychnine (Dosimetric Trinity No. 1) One granule of the combination selected should be given every 15 to 30 minutes until the pulse softens or the patient commences to sweat freely; then one every half hour or one hour as needed to maintain this effect. Keep the pulse at 80 or under if possible. Envelope the entire thorax (and from chin to low on hips) in a thin, close-fitting jacket, thickly “quilted” with raw cotton, or the common “batten,” well greased. If pain calls for treatment give a few doses of bryonin or hyoscyamine and oedeine singly or in combination as indicated. Always secure complete effervescence and rest, no matter how much drug is required. Some cases do better on the above formulas alternated. The treatment should always be adjusted to fit.

Clean out the primae viae with 1-6 grain doses of calomel and podophyllin half-hourly until one grain of each is taken; heaping teaspoonful of Saline Laxative in hot water and repeat every hour till bowels move freely; then give one or two 5-grain tablets (usually one) of the Compound Sulphocarbonates—Intestinal Antiseptics W-A—every two hours; or enough combined with occasional doses of Saline Laxative to keep the bowels sweet and clean. If stools are malodorous after they cease to be dark (almost black) in color, calcium sulphide granules, gr. 1-6 each (12 to 36 in divided doses daily) q. s. should be used as a systemic antiseptic, and nuclein should be pushed. Both intestinal and systemic antisepsis is of the utmost importance.

If seen early and properly selected remedies are pushed rapidly, nearly every case may be aborted. If the patient is naturally weak and has a rapid, thready pulse instead of a full, bounding pulse, always give strychnine arsenate in place of veratrine. Codeine may be used to quiet cough if required, and emetine to facilitate expectoration. Apo-morphine in small doses for expectorant and relaxation effect often works best of all. If the pneumonic condition exists in a very young or very old patient and he does not cough and clear the bronchial tubes sufficiently, the stimulating expectorant, sanguine nitrate, should be used in just dose enough to



produce sufficient coughing to rid the bronchial tubes of accumulated secretions. The complicating bronchitis may be as dangerous as the pneumonia itself. In such cases Calcidin (iodized calcium) is an exceedingly valuable remedy; furthermore, nothing can excel it for delayed resolution in any case. For the heart, strychnine has long been our sovereign remedy, but for heart waverings, in the earlier stages, we strongly advise the substitution of cactin, gr. 1-67 (one or more as needed), in place of strychnine. Later on, in cases foolishly allowed to run their course, the whip, strychnine, may be needed; and when rightly used will often prove a life saver.

It is of the greatest importance in all attacks of pneumonia to have a hyperleukocytosis present. For the production and maintenance of this physiologic state, Nuclein, Abbott, is the greatest known remedy. In the milder cases give 20 drops three times a day on the tongue without water. In the more severe cases give 20 to 30 minims every 12 hours by hypodermic injection into deep muscular tissues. Nuclein not only produces hyperleukocytosis, but it acts as a powerful stimulant to every cell of the body.

In all cases leave the patient on strychnine or the Triple Arsenates with Nuclein, and occasional doses of cactin for the convalescent period, and continue the Saline Laxative and Intestinal Antiseptics that you have used throughout the case, q. s., as required.

The gist of the whole thing being: Forced defervescence, elimination, intestinal disinfection, systemic disinfection, local protection and strong support to nature's fighting forces.—Abbott, in Clinical Medicine.

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### BOOK REVIEW.

**Suggestive Therapeutics, Applied Hypnotism, Psychic Science.** By H. S. Munro, M. D. This book treating as it does of things that are rapidly gaining ground in regular medical practice as well as in Christian Science, Magnetic Healing and other quackeries is probably the forerunner of other similar works on a more accurate and scientific plane. There is no logical reason why the regular physician should not use such things for the good of his patients who need mental treatment rather than medicine, instead of allowing them to go to the various quacks using these measures with the idea of self enrichment rather than for the relief of the patient. While there are contradictions in the subject matter the book is full of good ad-

vice for the treatment of nervous patients and it is written in a clear, forceful, convincing manner by a man who evidently has full confidence in the measures he advocates. The author does not advocate or believe in therapeutic nihilism but advocates the use of suggestion and hypnotism in certain cases by the regular physician in addition to medical and surgical measures and he pleads for these measures in a sincere and reasonable way. The book is published by the C. V. Mosby Book Co. of Saint Louis.—S. C. E.

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**The Sexual Instinct.**—Its use and dangers as Affecting Heredity and Morals. By James Foster Scott, A. B. (Yale) M., D., C. M. (Edinburgh). Late obstetrician to Columbia Hospital for Women, and Lying-in Asylum, Washington, D. C. 2nd Edition, revised and enlarged. 8vo. 474 pages, 111. Cloth, \$2.00. E. B. Treat & Co., Publishers, 241-243 West 23d street, New York.

EXTRACTS FROM AUTHOR'S PREFACE—This book contains much plain talking, for which I offer no defense. Its justification will be found in the body of the work, designed to furnish the non-professional man with a sufficiently thorough knowledge of matters pertaining to the sexual sphere—knowledge which he cannot afford to be without.

Science strips all draperies from the objects it examines, and, in the search after truth, sees no indecorum in any earnest line of study, and recognizes no impropriety in looking at objects under an intense light and in good focus.

The future prospects of humanity rest in the sexual domain of those who are now living, and none will dispute that the degradation of mankind is due more to sexual irregularity than to any other cause.

My knowledge of the subjects has been acquired through legitimate channels; as medical student at Edinburg, Vienna and London; then a residence of over two years in a hospital devoted exclusively to obstetrics and the diseases of women, followed by several years more of hospital and private practice.

Thus I have learned to appreciate and respect the role of women in nature, and to abhor the ignorance which will permit men to throw aside the elements of their manhood—veracity, cleanliness, health, and fitness for ancestorship.

Painful as it is to treat subjects so repulsive, a man cannot choose his duty, nor can he honestly evade it. Therefore, knowing of no other book of like character, I present this as the best effort

of which I am at present capable for the preservation of the individual and the welfare of the race.

The great danger when one undertakes to write on a moral or sociological problem is that one almost instantly becomes partisan and proceeds to present a brief for his side of the controversy. This is too often characteristic of books of medicine, and even in this case we find that Dr. Scott is trying to portray his subjective beliefs on the subject in hand rather than to make a fair array of the pros and cons of the whole problem. We all admit that the social problem is one that demands very active interest on the part of all well-wishers to our race. But your reviewer believes that man would sooner be persuaded by presentations of facts which they can accept and follow, rather than by special pleading. But, with this reservation, the book is a good one well worthy of the perusal of any who wishes to gather material for lectures to his patients or to the public on the subject.

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### University of Kansas—Schedules for Second Term.

#### JUNIORS

Hour	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00	Binnie	Surgery	Clinic	Schauffler	Block	Bruehl
10:00	Hanawalt	Lutz	Clinic	Wolf	Hanawalt	Griffith
11:00	Mosher	Hoxie	Clinic	Mosher	Hoxie	Griffith
1:30	Murphy	Trimble	Sawtell	McBride	Trimble	Sudler
3:00	Binnie	Trimble	Weiss	Bruehl	Trimble	Sudler
5:00		Curdy			Curdy	Sudler

#### SENIORS

8:00				Clinic (Scott and Griffith)	Perkins	{ Operative }
9:00	Longenecker	Sheldon	Clinic		Block	{ Surgery }
10:00	Laboratory	Laboratory	Clinic		Laboratory	Scott
11:00	Laboratory	Laboratory	Clinic	Griffith	Laboratory	Glasscock
1:30	..... Dispensary Sections. ....					
3:00	Guffey	W. J. Frick	Economics	Sloan	Payne	Clark
4:00						Sterrett

**Special Work:** St. Margaret's Hospital, 4 men, daily, 8:00 to 11:30.

Mo Pac Hospital, 4 men, Wednesday and Thursdays, 9:00 to 12:00.

Bethany Hospital, 4 men, Mondays and Thursdays, 9:00 to 12:00.

Bell Hospital, 2 men, externships (credit 5 hours).

Wesley Hospital, 6 men, Wednesdays, 9:00 to 12:00.

Dermatology with Dr. M'Bride, 2 men, one afternoon (credit 1 hour)

Bell Hospital, operative and demonstrative work daily, except Saturday, at 9:00.

# THE JOURNAL

OF

## THE KANSAS MEDICAL SOCIETY

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Volume VIII.

MARCH 1908.

Number 3

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### A DISCUSSION ON DIFFUSED SEPTIC PERITONITIS.

By CHAS. F. BOWERS, M. D., "The Barnes" Wichita, Kan.

Gentlemen: It shall be the endeavor of the speaker, in the discussion of this subject, to fairly present the commonly accepted position, as it stands today, together with such impressions which have come to me as the result of my own personal experience.

During the last decade, much progress has been made in the knowledge of peritoneal affairs; experience has brought wisdom and judgment; scientific research has furnished facts; bacteriologic study of the conduct and virulence of invading micro-organisms and an acute conception of the physiology of the peritoneum and the tactics displayed, by both peritoneum and invading forces, on field of battle, have added much to the surgeon's generalship in combating this most calamitous condition.

When cases of acute diffused peritonitis are presented to our service today, the outlook though always gloomy, is far more hopeful than it was a quarter of a century ago. We have learned to do certain things now which we then feared to do, and to leave undone certain things now which we then blindly carried out.

For example, we now open the abdomen at the earliest possible moment after the recognition of intra-peritoneal invasion of micro-organisms, remove the primary focus and establish efficient drainage, with the hope of cutting off further supply of invading toxic forces; we now carefully avoid visceral manipulation, evisceration, the removal of the protecting fibrinous lymph deposit, (nature's work of defense against further infection), and prolonged operative

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Read before the Kansas State Medical Society, May 9, 1907.



procedures.

Before advancing further let us obtain a mental picture of the commonly accepted mechanism of septic invasion and the processes of reactory defense. For these facts we are indebted chiefly to the labors of Mascatello. It was he who so forcibly illustrated that the upper dome of this extensive peritoneal lymph sack is by far the most active in the absorption of elementary matter in its several states, (gaseous, liquid and solid.) It is in this area also that phagocytosis is most active and efficient. And it has been shown (Dudgeon and Sargent) that phagocytes can collect with sufficient rapidity in this area, in obedience to the stimulus of staphylococcus albus, which so frequently precedes the invasion of the more virulent micro-organisms and establish an active defense to the migration of the latter.

The patient's physical organism must take the first step in repelling the invasion. The surgeon by his incision, his irrigation, and his drainage is acting only as the ambulance corps of the body, conveying away the dead and dying combatants on both sides, invader and invaded, and thus preventing the further poisoning which arises from their detention on the field of conflict.

Next to the diaphragmatic area, the portion of the peritoneum which suffers most in the presence of septic infection is that which covers the small intestines. Sir Frederic Treves has pointed out that infections tend to be more diffused in this territory than in those parts of the peritoneal cavity bounded by the caecum and colon at the sides, or in the true pelvis. Those of operative experience have frequently observed, in the presence of moderate infection, a fibrinous exudate, which agglutinates the infected coils of intestine in one mass, protecting the endothelial cell layer and thwarting the egress of organisms from the bowel, thus limiting the spread of infection; and further, converting a movable gut, to a fixed or splinted one, the value of which is known to all, in peritoneal inflammation.

The safety of the life of the patient thus afflicted depends on the integrity of the endothelial and phagocytic defense. In the event nature fails to react to the stimulus of infection, by virtue of over dose or extreme virulence, then the absorbing channels are open, toxins enter the blood stream in overwhelming doses and the patient falls victim to fatal septic intoxication. And again, by unwise irrigation and visceral manipulation on the part of the surgeon, injury is sustained to the endohelium with equally disastrous results.

These cardinal facts should be well kept in mind in the surgical treatment of this malady.

We owe our real knowledge of peritonitis to modern researches into the behavior of the various pathogenic organisms inside the peritoneum and the reaction of the membrane against this invasion. All our treatment must follow in the footsteps of, and wait upon this bacteriologic knowledge.

Intra peritoneal extravasation of blood is prone to be followed by the clinic features of an acute diffused peritonitis. Dudgeon and Sargent have found the staphylococcus albus in the blood clot of every case in a series of ruptured tubal pregnancies examined, and frequently, in the clot where the hemorrhage took place from mesentary, omentum, liver and spleen. In view of the above findings, it behooves the surgeon to thoroughly remove all clots, (though it requires irrigation).

Septic peritonitis arising from ruptured pyosalpinx is more virulent in character than when arising from hemorrhage. Our experience has led us to believe that acute specific inflammation of the tubes is of greater virulence than pyosalpinx of like origin. This may be due to two conditions—first the attenuation of the culture and secondly to the partial immunity arising from the previous inoculation. Septic peritonitis, arising from rupture of suppurating ovarian cyst, is of still greater virulence and derives its infection from the intestinal canal—usually of bacillus coli origin. The bacteriology of septic peritonitis of gastro-intestinal origin depends very much upon the location of the escape of the organisms. If gastric or duodenal the micro-organisms usually are stapho-diplococci or pneumococci, the virulence of which is not great.

The seriousness of the patient's condition lies in the resulting irritation produced in the peritoneal endothelium by the escape of foreign substances and the corrosive effect of the gastric juice which is followed by septic inflammatory process incited by micro-organism of greater virulence, derived from lower down in the intestinal canal. Hence the necessity of an immediate operation in which all foreign and irritating particles are removed and the breach in the viscus closed.

Next we come to the bacteriology of acute diffused septic peritonitis due to the invasion of the cavity by micro-organisms derived from the intestinal canal below the duodenum. Such cases have their origin in the escape of micro-organisms from a necrosed appendix with or without perforation, of intestinal ulcers, typhoid or

otherwise, intestinal obstruction from various causes, vraumatism or perforation of infected biliary, pancreatic or urinary passages. All these cases have certain common features—for instance, it is not absolutely necessary to have a perforation of the bowel wall in order to allow the escape of pathogenic organisms into the peritoneal cavity. The necessary condition in bringing about this migration of organisms is a distended bowel with attenuated condition of its walls and the presence in the lumen of fecal culture medium and organisms of an exalted virulence, such as are always found in intestinal obstruction and paresis. Thus it is, that the condition of the intestinal tube, and the bacteriologic flora at the time the patient is seized with the acute infection is a matter of great importance and has such a powerful influence on the ultimate issue—the matter of hygiene of the intestinal canal must be of prime importance in treating the disease.

Usually the first organism to migrate from the bowel in septic peritonitis due to intestinal bacteria is the staphylococcus albus; and as has been shown, their presence stimulates phagocytoses and increases the defense against the subsequent invasion of the colon bacillus. This improves the patient's chance of recovery, and the surgeon should be extremely careful not to molest this exudate which is so richly endowed with phagocyte.

There is a large group of very fatal cases in which the invasion is from the first due to the virulent bacillus coli—simple or multiples or the streptococcus pyogenes, in which the patient makes no reactionary defense, and death soon follows the onset of attack. The opened abdomen presents a peritoneum which has lost its luster, a thin turbid fluid free in the peritoneal cavity, no agglutination of intestinal coils, no fibrinous lymph deposited as is the case where nature has first made an effort to combat the disease.

There is still another form of diffused septic peritonitis, due to pneumococcus—occurring most often in children and twice as frequent in the female as in the male. The reason given for the more frequent occurrence in the female is that the infection many times can be traced to the ascending mucus currents in the uterus and fallopian tubes. This variety of diffused inflammation may end in a large collection of pus, free in the peritoneal cavity. Most of these cases give a history of an antecedent vaginitis, and the early course of the disease is characterized by a diarrhoea. Laparotomy irrigation and drainage affords relief, if undertaken before the patient is overwhelmed with toxins. The naked eye appearance



of the exudate is very striking, the thick greenish-yellow, odorless pus, with numerous flakes of dirty white fibrin, as described by "Janson."

One of experience in peritoneal matters, will readily recognize the characteristic appearance of the exposed and visceral peritoneum; odor, color, and consistence of the exudate; and form a comparatively accurate knowledge of the character and degree of virulence of the infection. This knowledge will influence, and will guide him in how much or how little is required to obtain the best chances for ultimate recovery. The inflammatory reaction is nature's attempt toward cure, and if it fails, it was because the task was too great, never because its generous intention faltered. In reality, every case of peritoneal invasion of micro-organisms would be fatal were it not for the inflammatory reaction. Back through time we hear reverberating the enunciation of "Lord Lister," "that if the invading forces be prevented from landing the country or body politic will remain at peace and the aid of inflammation will not be called for."

Having thus briefly reviewed the fundamental principles which underlie all our peritoneal therapeutics, we shall endeavor to discuss a rational treatment of acute diffused septic peritonitis. The construction of a rational treatment of diffused septic peritonitis is founded perhaps, upon three practical and scientific principles:

First: To remove the primary focus of the infection and to prevent the further landing of invading micro-organisms.

Second: To promote leucocytosis and increase the opsonizing power of the blood. The latter to so modify bacteria in a manner which render them an easy prey for the phagocytes and puts into action the machinery of immunization.

Third: To provide early escape from the peritoneal cavity for the debris arising from the conflict waged between leucocytes and pathogenic organisms, thus preventing the detention of products which in themselves are capable of destroying life, when absorbed and carried into the blood stream.

#### MEDICAL TREATMENT.

The administration of an opiate in some form would seem indicated for the relief of pain as a humane measure and to arrest peristalsis whereby the dissemination of infection is minimized, but on the other hand, this would mask symptoms and produce an illusory sense of betterment in the condition of the patient and in this way influence the attendant to delay operation and bring about loss of



valuable time. Again, opium has a marked inhibitory effect on leucocytosis, and lowers the opsonic index, the things above all not to be desired. And, further, opium increases intestinal paresis and accumulation of toxic producers in the bowels. If opium has a place in the treatment of this disease it is in the earliest stage and in sufficiently large dose to arrest peristalsis, however, we seriously question its utility other than as a pre-operative measure.

Lawson Tait pointed out the benefit that would be derived by emptying the alimentary canal of its toxic fluids, and thus purgation became a logic therapeutic measure, but he distinctly states in his original paper that only in the early state will benefit be derived.

In case of obstruction from any cause or perforation of the alimentary tract, or in the presence of paresis, an attempt to purgation would not only be of no benefit but a disturbing factor.

Serotherapy at present offers but little in this class of cases, inasmuch as in the vast majority of cases of diffused septic peritonitis the colon bacillus is the disturbing micro-organism, and as yet an anticolon serum is not at our command. The streptococcal infections are so rapidly fatal that there is less chance of successful serotherapy. In the less virulent infection the patient has time and is able to manufacture his own anti-toxins and then aided by wise surgical methods the chances for recovery are good. Owing to incomplete bacteriologic knowledge and in the absence of an efficient sero-therapy, the surgical treatment of this disease must remain a matter of much anxiety.

#### SURGICAL TREATMENT.

It is indeed, only in recent years, that surgeons have learned that it is necessary to work in harmony with organic processes of phagocytosis, opsonization and immunization, if we hope to aid instead of hamper the peritoneum in its defensive battle against infection.

As a general rule, a large class of cases of diffused septic peritoneal infection depend on their infection from some portion of the intestinal canal, and are of colon bacillus origin or in combination with staphylococcus. Here the surgeon should regard the diaphragmatic area of the peritoneal cavity as sacred and leave it alone, unless it is the primary seat of infection.

In the next place since the great majority of cases of this malady begin at one focus of primary infection, it becomes truly necessary that this primary focus be the seat of operative attack. Thus all localized collections of pus must be drained. The perforated or

gangrenous appendix must be removed and its occupied territory drained. The perforated alimentary tract must be sutured or the gangrenous portion of the bowel removed and intestinal anastomosis established. In like manner the ruptured gall-bladder or the ruptured pyosalpinx, or the suppurating ovarian cyst must be the primary object of attack.

Where the peritonitis is the result of obstruction of the intestine, from whatever cause, it must receive that attention necessary to overcome the obstruction, be it an ileus or an accumulation of feces or paresis.

When the peritonitis arises from distended intestinal coils, due to obstruction at the ileo-caecal junction from hyperplasia or a parietic condition in this territory, after an appendectomy, and the individual is doomed, the question of enterostomy should be considered. We feel that one life out of three thus operated was saved by ileo-enterostomy, although another operation later on was required to close the artificial opening in the intestine. Post operative ileus tending to a fatal issue demands enterotomy and emptying the intestine of its contents.

As a general rule, safety lies in making things secure locally, by the removal of the primary focus of infection, along with efficient drainage of the abdominal cavity and pelvis. This may be accomplished by the use of rubber or glass tubes, or by gauze enveloped in surgeon's rubber protective.

In diffused peritonitis due to the most fatal streptococcus pyogenes or bacillus pyocyaneus, the infection is diffused and virulent from the onset, and there is little, if any chance of dealing with the primary focus. It is in this class of cases that operations have yielded but little good. Laparotomy and extensive drainage in lower abdomen, with Fowler position and continuous saline irrigation as recommended by Murphy seems to be indicated.

There are cases of much milder degrees in virulence; viz: inter-peritoneal hemorrhage, perforated gastric and duodenal ulcers, in which the arrest of hemorrhage is the first instance and the closure of the perforation in the second, along with removal of all foreign particles from the peritoneal cavity is sufficient, if done early, and drainage will not be required, but if late it is better to drain.

Peritonitis of gonococcal origin due to extension from infected tubes, or ruptured pyosalpinx, should be treated in the same way, though the tubes should be removed and drainage established.

Peritonitis from perforation in typhoid fever calls for immedi-

ate closure of the perforation and thorough irrigation of this extensive lymph sack. The seriousness of the position lies in the patient's exhausted state, and the delay which occurs before operation; hence the extreme importance of an early recognition of the symptoms pointing to perforation.

#### POST OPERATIVE TREATMENT.

Place the patient in the "Fowler position" and administer saline solution per rectum after the "Murphy method", continuous irrigation under low pressure. This is said to reverse the lymph current, and thus neutralize the intra-peritoneal fluid, promotes leucocytosis, increases the opsonizing power of the blood and the semi-erect posture assists in directing the toxic products away from the diaphragmatic area, where rapid intoxication takes place when bathed in toxic fluids.

## EFFECTS OF TOBACCO.

BY W. L. CHILCOTT.

When tobacco is so universally used, when organizations are advocating its injuries, when legislatures are discussing and enacting laws for regulation of sale of tobacco—is it not high time that the student should endeavor to be informed as to the physiological effects of the soothing weed?

Kansas and Iowa have given the city council power to regulate the sale and distribution of cigarette papers. Missouri's last legislature discussed tobacco regulations. Nebraska's laws forbid the sale or distribution of cigarette papers. Utah's laws read: "Any person under age of eighteen years who shall buy, accept or have in his possession any cigarette, or tobacco in any form shall be guilty of a misdemeanor."

Allow me to state in the beginning that in this land of the free, this age of the enlightened, it is every man's—not boy's—privilege to use tobacco to his stomach's desire, so long as he does not pollute the air that his sister and susceptible brother must breathe, or stain the floors and walks upon which they must tread. I claim no man or woman has the authority to say I shall not smoke or chew when in my own barnyard, or a mile from any other human being.

As to scientific experiments upon human, giving proven results, I have been able to find very little; most of the experiments have been made upon the more susceptible animals. If you will bear with me a little while I shall endeavor to give you a few acceptable facts and opinions.

The Medical Journal of May, 17, 1902, gives the report of Dr. I. Alder feeding rabbits on cabbage mixed with an infusion of tobacco. An animal was killed at the end of two and one-half months which showed an enlarged liver, pale and granular, the liver lobulation being very pronounced. The proliferation of fibrous tissue follows the tract of portal vessels and bile ducts. The liver cells were normal; the change was restricted to intestinal tissue only.

B. Moore and R. Rowe made some very interesting experiments upon cat, dog, frog, etc. in the Physiological Laboratory at University College of London. They say the three alkaloids, piperidine, conine and nicotine, are very similar in physiological action.

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Read before the Douglas County Medical Society June 11, 1907.



The summary of this paper is as follows:

1. Subcutaneous injections (in frogs) in sufficient doses cause complete motor paralysis.
2. This motor paralysis is due to paralysis of the intra-muscular part of motor nerves.
3. The excised frog's heart is somewhat slowed and duration of systole prolonged.
4. The heart—in situ—in mammals is at first slowed, but afterwards unaffected.
5. The arterial blood pressure is enormously raised, and the rise is due to constriction of arterioles, and not to increased heart action. This constriction of arterioles is independent of connection with the central nervous system, and is probably due to vaso-motor excitation of peripheral ganglia.
6. At a certain stage, this vaso-motor mechanism probably becomes paralyzed, as further administration no longer affects the arterial blood pressure.

I. N. Langley, (M. A. F. R. S. Fellow and Lecturer of Trinity College), at Cambridge, performed many scientific experiments, some of which Howell refers to; others are given in *Journal of Physiology*, Vol. 15, P. 184. While endeavoring to determine the areas of skin supplied by each gray ramus, Langley found that by cutting sympathetic trunk above and below, the gray ramus and ganglion isolated so as to allow electrodes to be placed under it. Then by injecting 4c. of 1 per cent solution of nicotine into vein of cat, prevents reflex action of any kind. Before giving nicotine, he injected 2 c. c. of 2 per cent. solution of morphine or applied artificial respiration apparatus to keep life from becoming extinct.

In determining the position of sympathetic nerve cells connection, they injected about 10 milligrams of nicotine into the vein of cat, and it prevented all passage of nerve impulses through the sympathetic or homologous cells.

Nicotine annuls the pilo-motor effect of stimulating roots of the spinal nerves, as it does all other visceral effects; but it does not annul the pilo-motor effect of stimulating the peripheral nerves.

Previous to these experiments, Langley and W. Lee Dickinson performed other experiments on frogs and mammals to determine the physiological effect of Pituri and Nicotine. They utilized the fact that nicotine causes quickening and deepening of respiration, followed by slowing and cessation. They found that as little as one milligram of nicotine would stop respiration. They also found

that by sectioning brachial nerve, tonic rigidity of skeletal muscles of that arm did not occur; therefore, concluding that the effect of nicotine appears to be entirely due to a stimulation of central nervous system. They then found that, in a certain stage of nicotine poisoning, no movements can be obtained by stimulating the central end of a sensory nerve, but muscular contractions were readily obtained by stimulating peripheral end of motor nerve.

The effect of nicotine upon heart beat and blood pressure is made very clear by their experiments. Langley finds that small doses of nicotine stimulate, then, if dose is increased, paralyze the peripheral nerve cell on course of vaso constrictor and vaso dilator nerve fibers, which results in a greatly increased blood pressure lasting but three minutes, then a fall below normal.

They conclude that nicotine first stimulates, then paralyzes, the medullary vaso motor and cardio accelerator centers. They think, further, that it has, in general, a similar effect upon peripheral ganglia. On injecting nicotine, micturation frequently occurs and the poison is readily found in urine.

The American Text Book of Physiology says, "Tobacco smoke applied directly to nerves first stimulates, later anaesthetizes, and finally kills."

In Vol. 26 of Popular Science Monthly, Dr. G. Decaisne gives report of some observations as to the effect of tobacco in thirty-eight youths, from nine to fifteen years old, who were addicted to smoking. With twenty-two of the boys, there was a distinct disturbance of circulation, with palpitation of heart, deficiencies of digestion, sluggishness in intellect, and craving for alcoholic stimulants. In thirteen instances, the pulse was intermittent. Analysis of blood showed a marked falling off in number of red corpuscles in eight boys. Twelve boys suffered frequently from nose-bleed. Ten boys complained of agitated sleep and constant night-mare. Four had ulcerated mouths, and one of them contracted consumption.

Dr. Decaisne believed the effect to be due to great deterioration of blood produced by prolonged and excessive use of tobacco. The younger children showed more marked symptoms; and the better fed children were those that suffered least. Eleven boys had smoked for six months, eight for one year, and sixteen for more than two years. Out of eleven boys who were induced to quit smoking, six were completely restored to normal health in six months; the others continued to show symptoms for a year.

During a discussion in an American association, Prof. W. S. Dudley showed how the effects of cigarette smoking were injurious. He said in order to get the desired effect, many people inhaled the smoke; whereas in cigar or pipe, the smoke was simply drawn into the mouth, then expelled. In his experiments, he caused small animals to breathe air containing cigarette smoke, and found that after a mouse had smoked one and one-quarter cigarettes, life became extinct. Examination of the blood showed it had died from effects of CO, (carbonic oxide), which was contained in smoke, and not from the nicotine and other volatile products of the tobacco and paper. This CO is produced by the carbonic acid gas, which is first formed at the end of lighted cigarette, passing through the red-hot carbon, while the air is excluded. He affirms the smoke of cigar, pipe or cigarette, or Turkish water-pipe, would have same effect if inhaled.

Dr. Julinski, of Warsaw, has made some experiments upon the effects of tobacco smoke, which he determined to be a distinct poison, even in small doses. He asserts that its action on men is very slight when not inhaled in large quantities, but it soon becomes powerful in those who contract the habit of swallowing smoke, even when disengaged of nicotine, because he showed smoke contained a second principle called solanine, besides carbonic oxide and hydrocyanic acid. He goes on to say the effects produced by smoking depend upon the nature of the tobacco and the way it is smoked. He thinks the cigar smoker absorbs more of this poison than the cigarette smoker, and he more than one who uses a pipe. He concludes that the person who uses water in pipe reduces this harmful effect to a minimum.

Dr. Ralph C. Larrabee of Boston said the action of heart is reduced even by a moderate amount of nicotine, the effect being noticed very quickly. He thinks tobacco smoke contains from nothing to 50 per cent of nicotine.

Allowing that smoking must prevail, he would advise smokers to use long-stemmed pipes and keep them clean, and not smoke cigars too close to the end. No harm, he said, would result from suddenly and completely ceasing the smoking habit.

Osler says in his practice of medicine toxic angina embraces cases due to the abuses of tea coffee and tobacco. There are three groups of the so-called "tobacco heart":

- 1st. The irritable heart of smokers seen principally in young lads in which the symptoms are palpitation, irregularity and rapid



action.

2d. Heart pain of a sharp shooting character, which may be very severe.

3d. Attacks of such severity that they deserve the name of angina.

Huchard remarks that they are usually of the vaso-motor type, accompanied by chilling extremities, feeble pulse, and tendency to syncope. This author distinguishes between functional tobacco angina, due, he thinks, to spasmodic contraction of coronary arteries, and an organic tobacco angina, due to a nicotine arteriosclerosis of these vessels.

John V. Shoemaker, A. M., M. D., (Professor Materia Medica, etc., in University of Pennsylvania), says: "Tobacco is a acro-narcotic poison, acting energetically upon persons unaccustomed to its use. Its action is accompanied by great muscular relaxation; the respiration and circulation are depressed, the temperature lowered, and the surface becomes cold and moist with perspiration. The nervous system is early affected by the drug, the motor nerves are paralyzed progressively from the periphery to the central organs; there are no marked effects upon the sensory nerves. The spinal and central centers become effected, and incoordination, staggering gait, and vertigo are prominent symptoms of the toxic action. Similar effects also follow the inhalation of tobacco smoke, though generally they appear in much milder form than when the drug is swallowed.

The slightly depressing effects resulting from a moderate use of tobacco, the power of increasing the secretions along the alimentary canal, while favoring peristalsis, and the functions of the kidneys, are valid arguments for moderate indulgence in the post-prandial cigar; but there are also psychic effects which follow its use. It allays restlessness and muscular irritability, and creates a lassitude which is favorable to the pleasant flow of fancy so happily illustrated in the "Reveries of a Bachelor." The fact that it is a sexual sedative may or may not contribute to its popularity among those who lead sedentary lives, and who find it helpful to them from experience of its effects, rather than from any judgment based upon an exhaustive knowledge of its physiological action.

Murray, a distinguished oculist, examined four thousand persons and found 3.01 per cent color blind. 2.58 per cent had weak chromatic sense caused by use of tobacco.

The Journal of American Medical Association, (February 15,



1890), reports many cases of Tobacco Amblyopia by Leartus Connor, A. M., M. D. He showed,

1st. That tobacco has an especial affinity for a central tract in the optic nerves, and may induce central amblyopia.

2d. No other single agent has been shown to induce central amblyopia, symmetrical in both eyes, in strictly non-users of tobacco.

3d. Some especial conditions are required to precipitate an attack, as abuse of alcohol, diabetes, excessive venery, starvation, mental shock, or distress, etc.

4th. Some individuals seem to have an especial tendency to optic nerve degeneration., and to these, the use of tobacco is specially injurious.

5th. Clinically, central amblyopia is recognized by its sudden development, by the existence of central scotoma for color in both eyes without limitation of the fields of vision, by the absence of any effect of refraction or recognizable lesion to account for the sudden blindness, and by its occurrence only in tobacco smokers.

6th. Pathologically, during at least its earlier stages, it consists of an anaemia of the central portions of the optic nerves. Possibly this may, after a longer or shorter time, induce organic disease; but this has not yet been shown in a case of pure tobacco amblyopia. Its prognosis is good during the earlier stages, at least, if properly managed.

7th. Its treatment consists principally in withdrawing the tobacco. Other measures may be profitably employed that promote the local nutrition of the eye and the system in general. The optician of this little berg has patients afflicted with amblyopia, some of whom he can induce to desist for short periods; then, when apparently recovered, they take to tobacco again which brings a return of ailment.

R. L. McDonnell, in making his report on the family life of cigar makers of New York City, says, in three hundred and thirty-seven families there was an average of but 1.63 children to the family. One writer attributed the race suicide of France to the excessive use of tobacco. Another believes that the strong, sturdy, energetic Turks have deteriorated on account of the tobacco habit. All physicians believe that an excessive use of the soothing weed lowers one's resistance and reduces the power of repair.

Very few will dispute that it does lessen one's finer sensibilities of his social relations. The effect of excessive use is very

nicely expressed in the song, "Everybody works at our house but my old man." Or, also, the story of "Rip Van Winkle" is another example of the deteriorating effects of tobacco.

It seems to me that these toxins of tobacco must cause to be created an anti-toxin, anti-tobacco-opposite side claims on something to neutralize the toxic effect, the same as is done on invasion of any other poison. If one begins the use gradually, with less than toxic doses, he may acquire this immunity without the serious symptoms gone through by nearly every boy—and many girls, too. I have seen Indian Territory church women use snuff and have spitting contests during services.

These anti bodies surely have their injurious or irritable effect upon the victim when they are not neutralized, but allowed to accumulate. The anti body calls for the toxin, then the toxin calls for more anti body, which keeps calling for more and more, vice versa, until one's will power is outdone.

Some claim tobacco works in a similar manner. What wife, when trying to live in peace with her irritable tobacco-weaning husband, will not exclaim, "For harmony's sake, go buy some tobacco."

Some of the world's most brilliant men have been continuous smokers. When such men as Bismarck, Grant, Holmes, Tennyson, Stevenson, DeWitt and Dr. Clark were excessive smokers, is it any wonder that the ambitious boy is willing to sacrifice several delicious dinners, endure numerous reprimands and part with many nickles in his effort to follow in their footsteps?

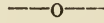
Tobacco, then, is a sedative pure and simple, with narcotic effect, which is readily felt by habitual users when excessively indulged in. Whether or not it will affect the American as it has the Turk remains to be seen.

The future indicates a reduced use, instead of increase, as the school boy of ten to fifteen is becoming informed as to its injurious effects.

While there seems to be very little harm done by mild indulgence, very few advocate any benefit derived by its use, unless their system is being irritated by the accumulated anti-nicotine bodies. It isn't necessary to wean the old indulgers; only prevent its use among the young, and in a few years 'twill be a habit of the past.

Sir Isaac Newton was a continuous smoker; he even had to indulge in the filthy habit when calling upon his sweetheart. Sir

Isaac was a bashful sort of a fellow, and had been calling upon this fair one for many months, never so much as patting her cheek or squeezing her hand. One day her heart leaped for joy as he suddenly seized her hand, she thinking the happy moment had at last come; but alas, Sir Isaac absent-mindedly began to probe an obstruction from the bowl of his pipe with her little finger.



The following articles will be added to the list of New and Non-Official Remedies approved by the Council on Pharmacy and Chemistry:

Bromural (Knoll & Co)

Elixir Buchu, Juniper & Acetate Potass P-M Co (Pitman Myers Co)

Tablets Acet-Phenetidin Comp P-M Co (Pitman Myers Co)

Sryup Cannibis Comp P-M Co (Pitman Myers Co)

Veroform Antiseptic (Veroform Hygienic Co)

Veroform Germicide do

Very truly yours,

W. A. Puckner, Secretary

## THE EYE IN ITS RELATION TO SYSTEMIC CONDITIONS.

BY H. L. SCALES, M. D., Hutchinson, Kan

The eye in its relation to systemic conditions is a subject so vast that in a paper such as this, which is intended to be read before a body of general practitioners, only a few of the commoner and more important conditions will be discussed. The subject must be considered from two standpoints. First, systemic diseases that cause pathological conditions in the eye, conditions originating in the eye that cause pathological or reflex systemic symptoms. Diseases of the kidney are often accompanied by eye complications that afford valuable aid in the diagnosis and prognosis of the kidney lesion. In a nephritis failing vision, due to an albuminuric retinitis, is often the first symptom that causes a patient to suspect that he is not well. On opthallescopic examination a retinitis is discovered that is often so typical of Bright's Disease, that the diagnosis can be made from the retinitis alone.

Albuminuris retinitis is so common during pregnancy that any decrease in the vision of a pregnant woman should be looked upon with suspicion and a careful examination of the urine made. Even if no albumen is found an apthalmoscopic examination of the fundus should be made as there may be a retinitis and no albumen be found. However, repeated examinations will always demonstrate the presence of albumen or casts, or both. Albumenuric retinis is not only an important diagnostic sign, but has also an important bearing on the prognosis. Retinitis occurring in a chronic nephritis usually comes late in the course of the disease and a prognosis can be made of a fatal termination in from six months to two years. In acute nephritis the prognosis is fairly good both as to recovery of vision and from the nephritis, but even in an acute nephritis with retinitis the ultimate prognosis is not very favorable. A case of each form will illustrate: Mrs. H., age 56 while on a visit to St. Louis in February, 1905, noticed that the vision in one eye was failing, and consulted an oculist, who prescribed glasses. On the way home she spent a week in Wichita and while there consulted another oculist, who found what he thought was beginning retinitis and found albumen in the urine. On her return home she consulted me, and, while there was no doubt of the retinitis, I found no albumen. This was no doubt only a transient absence



as her condition did not improve, and she died February 1907 of nephritic coma. This case lived much longer than the average case, but she was seen very early in the retinitis; so early that the diagnosis was a little in doubt.

The case of Mrs. J. illustrates a retinitis occurring in a case of acute nephritis. Mrs. J., age 22, was delivered of her first child without anything that would indicate a nephritis except a rather severe headache. Did well until one week after confinement, when she complained that she could not see objects plainly across the room. On ophthalmoscopic examination a typical albuminuric retinitis was discovered in both eyes. The urine was loaded with albumen; under appropriate treatment vision was regained, albumen disappeared, and the patient two years later is apparently in perfect health. It has been said that no disease is such a scourge as syphilis, and certainly no one disease causes such devastation in the eye as does syphilis. The most common eye diseases due to syphilis are iritis and keratitis. Probably 50 per cent of all cases of iritis are due to syphilis. Iritis usually occurs in acquired syphilis rarely in heredity, and with proper treatment should recover with good vision. But unhappily many of these cases are neglected until adhesions take place and an effusion is thrown out and recovery takes place with a crippled eye. In inherited syphilis the eye lesion most common is interstitial keratitis. The unfortunate child who suffers from interstitial keratitis is truly an object of pity. The usual course extends from six months to two years, and even with a good result they are practically blind during this time, and recovery is never perfect. Rheumatism, malaria, auto toxemia and many other diseases cause serious pathological conditions in the eye. Within the last year autotoxemia has been more and more suspected of being the cause of many diseases of the eye in which the etiology has heretofore been obscure. Within the last few months Dr. Schweinetz had an elaborate paper in the Journal of the American Medical Association on this subject, and while he did not endeavor to make positive statements as to the acute toxemia being the cause of many eye diseases, yet he laid the foundation for further study along this line. Pathological or reflex systemic symptoms caused by conditions originating in the eye, and usually due to eye strain and this alone will be considered. Eye strain is due either to some error in the refractive media or to muscle imbalance. Of the many symptoms due to eye strain by far the most common is headache. And it is also true that

from 75 to 90 per cent of all headaches are due to eye strain, and can be relieved by properly fitted glasses. Eye strains most common effect is on the nervous system and in many conditions that we designate as neuresthenia the underlying cause can often be traced to eye strain. This element should not be lost sight of by the surgeon in his gynecological cases as in many women with conditions demanding operation there is a complicating eye strain and the results will be much better if the refractive error is corrected. The relief of the eye strain will often relieve the nervous element that prevents a perfect recovery. For several years the question as to whether or not eye strain was a cause of epilepsy has been bitterly discussed through the journals with very emphatic statements from both sides. I have one case of undoubted epilepsy that was cured by proper refraction. Miss A. B., age 16, had been under treatment for epilepsy for one year prior to January, 1905, with the attacks increasing from one a month to seven or eight a month. Suspecting eye strain from other symptoms and not with much thought of benefitting the epilepsy, she was refracted under atropine and given full correction for a compound hyperopic astigmatism. She was continued on the same line of treatment, and, to my surprise, the attacks ceased and she has never had a recurrence. It has been over 26 months since the last attack, and I think she can be considered cured.

In closing I would like to ask you to keep in mind the eyes as a probable cause in all cases of headache or in nervous cases in which the cause is obscure.

## MEDICAL SCIENCE.

BY T. A. STEVENS, M. D., Caney, Kan.

When I decided to write a paper on the subject of Medical Science, I addressed a letter to a few well known and successful medical men, asking for suggestions that would help me in its preparation. While I have taken advantage of the thoughts expressed by others, the following is a sample of nearly all of the replies received. "While I may have been long on the practice of medicine, I am certain I am short on the science of medicine, in fact, long since I had concluded that medicine was not at all a science." Then I remembered the rather gloomy aspect of the paper, the 'Internist,' read before this Society last year, by the able gentleman, Dr. J. M. Latta. All this had a somewhat cooling effect upon my ardor, but appreciating the environments of the hour, and the dignity and culture of this select convocation of men and women, representing a noble profession in a great State, it were rashness to come before you with this paper, with its incompleteness and its imperfections, without feelings of trepidation and solicitude, lest I should fail to interest and benefit you.

Being much enamored of Medical Science, and jealous of its true dignity and importance, I hope I shall be pardoned if my theme is a digression from the ordinary and the routine on occasions like this. I am inclined to barter the technical for the practical, and speak of the inalienable birthright of the physician, his true sphere and position as a professional man. Today, as never before, he is appreciated as an essential factor in life's economy. Science has laid her richest bequests at his feet, placed her most secret discoveries in his hands, and is relegating the quack and the conjurer to their proper places in the ignorant past.

The modern physician is an evolution of science, the product of progress. The medicine man of the past, and the physician of the present, are peculiarly diverse.

Medical science begins with mystery and works itself out into the plausible and practical. We do not know what life is, but we know it exists under fixed laws, survives under certain conditions or environments. To study these complex and subtle laws of being and repair their violations is the sphere of medical science. Biology

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Read before the Kansas State Medical Society, May 10, 1907.

physiology, and kindred sciences endeavor to take us up to life's fountain head, where we catch a glimpse of the embryonic fires in which life's warm currents are generated, and watch the coming into view of vital forces which make life's great river.

The practice of medicine is the going down into the damp miasmatic valleys where the streams have become foul and murky and stagnant, and as best we can open its channels, deepen its currents, purify its waters, eliminate its defects, restore its harmony until the heart's pulsings shall be as the rhythm of some exquisite poem; therefore medical science has to do specifically with physical life, and of necessity, its antithesis, death. It assumes to be life's guardian and death's sworn and skilled enemy. It is pledged to the amelioration of human suffering, the easing of human pain and the binding up of its wounds. In such high emprise, we as practitioners are engaged, and to such lofty ends is medical science devoted.

The practical application of medical science or the practice of medicine is interesting in itself, but when we view it from a needful and benevolent standpoint, it is the supreme science of the age. As it learns it gives out its blessings, and as it receives it bestows in pure coin like gold. Indeed, the medical contributions to humanity within the last one hundred years have been broad and benevolent.

Her practical achievements have been marvelous. Medical science has recently devoted itself to the modes of preventing disease with wonderful success; the value of cleanliness; the adaptation of food and clothing and the intelligent observance of hygienic laws has greatly decreased mortality and contributed to human longevity. So late as 1870 the average duration of human life was about thirty-three years, today it is reckoned at forty-two and one-half years. Medical science has reduced the mortality among children in the last quarter of a century, about one-third.

Hippocrates, "the father of medicine," William Harvey, the distinguished discoverer of the circulation of the blood, John Hunter, the father of surgery; Edward Jenner, who by his discovery of vaccine for smallpox, has saved millions of human lives; Galena, the prince of physicians, and Columbus who succeeded him; Malpighi, who introduced hypodermic medication; the great work of Charles Darwin, followed by Haller's work on the irritability of Protoplasm; Virchow, with his cell doctrine, Pasteur on bacteria and immunity; Robert Koch, who isolated and demonstrated the



germs, and who with Virchow established one of the principles of immunity, which probably promises more than all else to minimize human suffering, and others, have builded the foundation upon which medical science stands, and upon which so much is now, and will be achieved.

Briefly stated, these are some of the achievements of our profession, a few of the trophies we have gathered, some of the laurels which crown the brow of medical science, while she looks into the future full of hope and promise.

Science, hearing the pathetic wail of the infant, and the groanings of age, and seeing the color fade from beauty's cheek, and the strong man bowing to the destructive behest of disease, and moved by the pathos of that scene, has kindled her beacons and entered the arena to save. She has fought with superstition, struggled with ignorance, been challenged by prejudice, battled with diverse, watched symptoms under the feeble glare of the mid-night lamp, braved the danger of pestilence, the most fatal of epidemics, with a heroism which amounted to martyrdom, in order to understand disease and subdue it.

Medical science has done more to eliminate superstition than all else combined, until now it enjoys the position of peace, progress and power. The less superstition, the greater is civilization.

The progress of the profession tends continually to its elevation; the practice of medicine is no mean calling; the novice and neophyte has much to learn, and the quack and the counterfeit must fall out of the ranks.

The medical profession demands the most cultivated brain and the truest and best types of manhood to do it full honor. The physician is not as other men; peculiar and intricate and endless are the demands upon him. He is the child of the storm, as well as the calm and sunshine; he is the messenger of the night as well as of the day. God shall write in some enduring temple of fame the names of good true men and women who have administered to human suffering; nameless heroes here who in tent, hospital and hut of poverty and battlefield, have relieved pain and ministered to suffering, and took away the pangs of death.

This is perhaps the sentimental side of a physician's life, but I know as well and by experience, he should not be careless with his words, extravagant or idle in his opinions. His very calling demands that he take into the sick room a heart of gold, nerves of brass, a clear, cultivated brain, and all those splendid affabilities

and courtesies which belong to the most splendid specimens of men.

Her practical achievements have been marvelous. The basis of all of the compounding of medicine is chemistry; the development of chemistry as a science and the consequent ability to prepare medicines with a view to their chemical value, belongs to the past century. Medical science has made the basis of all treatment diagnosis or the discovery of the real nature of the disease to be treated. This depends upon a physician's knowledge, and this knowledge is about as recent as chemistry. It is only about one hundred and fifty years since the first medical college was organized. In 1800 there were but five in this country, now there are over three hundred. Surgery, that sad necessary to the maintenance of human life, has made wonderful advances, mainly because of knowledge of anaesthesia and more recent knowledge of asepsis. The priest is not more conscious of the violation of moral law than the physician of the flagrant violation of physical law. His confessional is the consulting room or the sick chamber, where one great physical law brings rich and poor, youth and age on one common level and one common bar to answer for the violation of laws as sacred as those of the decalogue. Things that should be sealed and inviolate are his only data in the treatment of disease. Science relegates to him the exploration of the beautiful and intricate and hidden temple of nature, because of his knowledge of its delicate and splendid poise, that he may discover and repair its defects. He is an encyclopedia of unwritten history, which if published, would perturb the otherwise placid face of society, and perhaps mar the peace and poise and happiness of homes. He is the legitimate actor in the suffering drama of life, whose worthiest and bravest deeds are not always appropriate to a proclamation in common language in the ears of the multitude. He is the custodian of things sacred. These are some of the things which he inherits, which society bequeaths to him as his portion and birthright. A medical education is no mean attainment, and the medical profession is no mean calling. Its true position and influence in social economics is being recognized. The practice of medicine is more than a fee for services rendered, it is more than food and raiment and a competency when age and infirmity come to us. It is loftier in its conception, grander and more far-reaching in its results.

The Kansas Medical Society year of 1907 is gone, we stand on the threshold of the new, where honor is to him who will win it; there is scope for the broadest culture; for the highest ambition and

grandest attainments. A mighty thrilling force permeates land and people, the counting house, the mill, the factory, the machine shop, the laboratory, the forge, the furnace is inspired with an activity which is continuous and extensive, investing material forces with an almost spiritual charm. Vast, immeasurable expenditures of power, resulting in magnificent attainments. Life, society, the arts, the sciences, the humanities seem to be approaching their final stage, "The Augustian age of humanity." An epoch which means a crown of glory around prophet and teacher and statesman and scientist. The medical profession has taken position in the front surge of the battle as humanity struggles on to perfection, and as the immortalities and abiding is achieved, medical science is elevated to a permanent place, it has come to stay. Humanity's pulse is in its scientific hand, and its heart throbs are noted, its weaknesses are discovered, and she is ransacking ocean and earth and air for remedies to heal its wounds. Other professions may lose their utility in the progress of things, but the medical profession is the one indispensable thing. The religious devotee may forget the priest and the altar; the lover may forget his impassioned vows; the mother may forget her babe after it is delivered, but man smitten with pain will not forget to seek relief.

Human life and the kindly offices of the physician are indispensable. The maker of swaddling clothes may precede us to a home on special mission, and the undertaker and the clergyman may make one visit after we depart, but the physician is present when the throes of nature's anguish announce the advent of a human being into the world, he is his constant companion and help in his earthly house of pain and suffering, and in the last battle mortality makes for existence he is there and notes the failing pulse as the pallor of death creeps into the cheek, and the death damp settles on the brow, and does not forsake him until the soul has departed on its long mission, gone into that mystery which we call eternity,—such is the relationship of medical science to human life.

In conclusion, let me say to my coadjutors, composing this Medical Society, may the God of Medicine and Healing prosper you in all things which are legitimate and right, and may each of you achieve something for the good of the profession in your respective and versatile fields of labor, and may all of our achievements be for the increasing of the splendor of the crown upon the benignant brow of medical science.

I desire to speak more particularly of the proposed education

for the public. The knowledge of the great work done by the profession for the amelioration of the sufferers of mankind, its philanthropy, its contribution to the happiness and comfort of man is so segregated that the public only faintly realizes its vast import. To the teachings of the medical profession, society owes for its perfected civilization, its sanitation, consequently its general good health more than to all else combined. Its teaching of the truths necessary to the happiness, comfort, contentment and prosperity of man has not been excelled by the combined influence of the clergy and statesman.

I believe that each county society should select a lecturer who should by pen and upon the rostrum inform the public of the great work that medical science has done and is doing now for both civilized and uncivilized man.

Education would relieve the public of the idea that a quack, a traveling "specialist" etc., is one who possesses superior knowledge and does such work that the ordinary doctor cannot attain.



## TREATMENT OF ABORTION

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HERBERT RANGLES, M. D., White, City, Kan.

Abortion treated by methods formerly in vogue caused acute and chronic diseases of the reproductive organs and made many invalids. The same is true in some cases at the present time because of the careless manner in which they are handled, but results are very satisfactory when the proper methods are followed, and it is even possible that the pre-existing endometritis which caused the abortion may be cured by correct treatment of the uterus at the time of the abortion.

In considering treatment we make several divisions, viz: threatened, inevitable, incomplete and missed abortion and the abortion habit.

Time will permit me to take up only a portion of the treatment and will consider that for inevitable and incomplete abortion which cases are much more frequent since many neglect to consider the physician until the preventable stage has passed. Much has been written in discussion of the merits of the so-called expectant and active plans of treatment and, while much can be said in favor of both, and in certain cases, for definite reasons, the expectant plan may be best; still I am convinced that in most cases active interference, as soon as the abortion is considered inevitable, gives the best results, even though not demanded by reason of hemorrhage.

I find that many prominent obstetricians have practically abandoned the expectant plan.

If the uterus has expelled the embryo and its membranes and the physician has the opportunity to examine the same so as to be reasonably sure that the uterus is empty, and the hemorrhage has ceased, it is best to interfere as little as possible and allow nature to handle the condition but, I find that this is seldom the case and more often only a portion, if any, of the product of conception has been expelled.

Under these conditions the two plans of treatment above mentioned are recommended—the ergot and “do nothing” plan, which is still followed by a few, is not safe and should not be used.

By the expectant plan we mean the use of a well placed

Read before the Morris County Medical Society at Council Grove, 9-17 '07.

vaginal tampon which balloons the vagina and usually stops hemorrhage and assists in the expulsion of the uterine contents. This is allowed to remain for 8 to 12 hours when on removal if the embryo is not found in the vagina, the tampon is renewed and removed within 8 to 12 hours. If then not successful the cant must be used.

The active plan consists in the thorough removal of the embryo and its membranes as soon as it is decided that abortion is inevitable. This I will describe more in detail.

First, last and always, strict asepsis must be observed. This, however, is hardly less important when the vaginal tampon is used. The patient should be partly, or completely anesthetized. If she bears pain well she can be managed by giving, hypodermatically, 15 or 20 minutes previous to the operation, morphine  $\frac{1}{4}$  and atrophine 1-150, and then giving ether to primary anesthesia only. Ether is safer than chloroform, especially if there has been much hemorrhage. With the patient in the lithotomy position, the hair of the mons veneris and labia majora should be shaved or closely trimmed, and the whole region including the lower abdomen and thighs should be scrubbed with green soap and hot water, followed by a good antiseptic such as Bichloride 1.2000 or alcohol or both. Then the vagina should be treated in the same manner and finally douched.

With a good perineal retractor in place, the cervix is caught with one or two double tenaculi and without much traction the uterus is steadied and the os dilated with a branched dilator such as the Goodell, to about  $1\frac{1}{2}$  inches, and a medium sized dull curet is very cautiously introduced and carried to the fundus. It should have a hollow stem and be attached to a fountain syringe containing 2 quarts or more of sterile 1 per cent lysol solution which is allowed to flow, and the embryo clots, etc., which can be easily removed are gently scraped out, systematically covering all parts of the uterus passing the curet from fundus to cervix and giving special attention to the cornea. After thorough irrigation the uterus is packed with 10 per cent. iodoform gauze. For this purpose the metal gauze packer and packer strips are very handy. A light tampon of iodoform on bichloride gauze is placed in the vagina. The packing should be removed in 36 to 48 hours and the vagina cleansed thoroughly.

The after treatment consists in rest in bed for one week and the use of ergot and strychnine to assist involution.

Various modifications of the technique are used by different

operators, but I believe this to be the best unless called for by some special condition. Dr. J. Clifton, leader of Cornell University, says that the tampon in the uterus is unnecessary unless called for by reason of hemorrhage which is not stopped by the curet. While Dr. A. P. Davis of Jefferson, gives it an important place. It has been my experience that it is quite essential as it assists in detachment and discharge of the decidua, lessens hemorrhage by stimulating contraction, provides for drainage and hastens involution.

A recent case emphasizes this: M. W., age 24. First pregnancy of about 2 months duration. Good family and personal history except for some disorder of menstruation, which was never diagnosed definitely and was treated indifferently. On June 30th the patient became overheated and on the following day colic pains and watery discharge from the vagina began. On July 2nd and 3rd the discharge was slightly bloody, but pain and hemorrhage ceased entirely after rest in bed and administration of chlorodyna and black now. Later the pain and hemorrhage returned and on July 12th it was decided that abortion was inevitable and a temporary tampon was placed in the vagina to stop hemorrhage till curettage could be arranged for.

The technique already described was followed except that I omitted the packing of the uterus.

Recovery progressed quite satisfactorily but was prolonged and after the discharge had almost ceased it suddenly became quite bloody and a small amount of debris and clots was expelled showing that drainage had not been perfect.

From former experience I am satisfied that the uterine packing would have hastened recovery if it had been used.

Some remove the packing in 12 hours or less, but 36 to 48 hours is none too long to accomplish the results desired, and if iodoform gauze is used no harm can come from allowing it to remain.

Asepsis is of first importance and if not strictly observed more harm than good may be done. It is quite tedious to carry out all of the detail but if we would be more careful in both confinement and abortion cases we would have fewer cases of puerperal infection and the resultant chronic ailments. In fact my experience leads me to believe that puerperal fever may be about entirely eliminated in country practice by thorough aseptic precaution. Occasionally auto-infection occurs but not so frequently as in

cities where gonorrhea and such diseases are more prevalent, and usually infection comes from without.

It is not always easy to carry out strict aseptic and antiseptic technique with the accommodations which we often find in private houses, but we can always have boiling water and I believe that this ought to be used in sterilization, where possible instead of depending on chemicals.

For the hands and for ears and the female parts the liberal and thorough use of soap and hot water with a brush continued for 3 to 5 minutes followed by antiseptic solution will accomplish more than when too much confidence is placed in antiseptics.

After the hands and instruments have been sterilized it is very easy to allow them to become septic by their coming in contact with clothing, towels, etc., which are not sterile, but it can be avoided by a little caution. Because women only occasionally become infected when these precautions are not taken is not sufficient reason for being lax in the matter.

Some operators use the sharp curet and those who are using the instrument often may use it with safety, but for general use the dull one does satisfactory work and is safer as the uterus may be perforated quite easily in some cases if care is not used, especially in carrying the curet to the fundus. The average results will be better if the acute treatment is used from the beginning in all cases for the following reasons:

1st. there is less hemorrhage, even though it may not be excessive by the expectant plan, convalescence will be shortened by lessening the loss of blood and anemia, which results.

2nd. Thorough drainage is secured which lessens the danger of infection and inflammation and resultant acute and chronic diseases.

3rd. No abortion is complete when the ovum comes away since the decidua is much more vascular at the time than it is after the third month when the placenta is more fully developed and by the curet and packing more rapid and thorough separation is secured..

4th. We are sure that the uterus is empty and we cannot be in any other way.

5th. Involution and convalescence are hastened and there is less suffering for the patient since the abortion is completed rapidly and usually 6 to 8 days in bed is sufficient, while with the expectant plan the completion of the abortion is prolonged and the



tampon causes pain and inconvenience and two weeks in bed is required to bring the organs to as good condition.

6th. An endometritis which caused the abortion may be cured by this treatment of the uterus.

7th. The patient is safer since a vaginal tampon may be expelled during the physician's absence and hemorrhage become dangerous.

8th. The expectant plan causes pain and suffering and is often unsuccessful requiring active treatment, eventually.

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## PROPRIETARY EPSOM SALTS.

By LLOYD A. CLARY, B. S. M. D. ; O. B. WYANT, M. D.

Winfield, Kan., Jan. 6, 1908.

To the Editor:—Believing that a discussion carried on in private will do absolutely no good to any of the parties concerned and also believing that the following, when presented to the profession as a whole, may accomplish some good we are sending you this communication together with the letter attached for you to present through the columns of the Journal.

To begin at the beginning. At a meeting of the Cowley County Medical Society a paper on "Proprietary Medicines and the Relation of Doctor and Druggist" was read. Dr. Wyant had prepared thoroughly for the discussion, especially having studied the phase of the subject pertaining to the method in which a manufacturer should present his product so that it could be given the support of the honest doctor, and this without detriment to either. He also went fully into the subject of the way the druggist should handle, advertise and push his products (both "patent" and proprietary medicines). This meeting resulted in some good though, of course, there are always enough luke-warm brothers in any county society to almost make those with higher ideals and advanced views pull their hair in despair.

In the paper above mentioned the following was said of Abbott's Saline Laxative: "We have heard doctors in our county society meetings endorse Abbott's Saline Laxative. Do you find this preparation among the pharmaceuticals on the druggist's shelves? No, it stands out boldly among the "patents" and is sold as such. Do you know what it contains? Do you think it just and fair to the patient to ask him to buy a can of this stuff at 50 cents when the label boldly proclaims it to be 60 per cent magnesium sulphate in effervescent combination? Why not prescribe magnesia sulphas effervescens U. S. P., under its own name and have the druggist put it up and dispense it at better profit to himself and at a saving to your patient?"

This was a plain plea, it seems to us, for the use of U. S. P. products—or more especially one of them—and the discarding of a preparation practically the same as the official one in formula though costing the pharmacist and consumer much more. It was simply the plea of the Council on Pharmacy and Chemistry and of all sensible, progressive pharmacists and physicians—the plea to lay aside proprietary products wherever and whenever the U. S. P. and N. F. contain the same or practically identical preparations or when the proprietary preparations can be laid aside with benefit to physicians or patient—which, by the way, is not seldom. We did

not discuss Abbott's Saline Laxative at great length nor go into detail about it, simply calling attention to its contents—not vindictively—but simply trying to open the doctor's eyes to the folly of using the preparation—considered from a business standpoint.

The paper was published in the Journal of the Kansas Medical Society, Nov. 1907. Shortly after its appearance there the following letter reached the author of the above mentioned paper:

Chicago, Nov. 29, 1907.

Dr. Lloyd A. Clary, Winfield, Kans.

My Dear Doctor:—I notice in the last number of the Kansas Medical Journal your objection to the druggists putting Abbott Saline Laxative among the patent medicines. If you will kindly indicate to us any means of preventing the druggist doing this after he has bought and paid for the preparation we would be exceedingly obliged to you. I have read and reread what you have to say to see if there was any further objection on your part to the Saline Laxative, but if there is your article does not say so. Should there be any further objection to this saline laxative, or the way it is handled by the proprietors we would be exceedingly obliged to you if you would let us know.

Very sincerely yours, Dr. W. C. Abbott.

The recipient of this letter had to smile when reading it. The trick was very apparent—very clear. It is really quite a clever letter. Doctor Abbott asks us to indicate a means of preventing druggists placing Abbott's Saline Laxative on their "patent medicine" shelves. At first you feel inclined (perhaps) to sympathize with the poor, weak, helpless manufacturer. It's too bad! He tries his best to do the right thing by the "dear doctor" but the all-powerful, overbearing, tyrannical retail drug man in his majestic might sets at naught all the worthy efforts of the poor, feeble manufacturer, and with satanical glee places the pure, wholesome and super-ethical can of salts on the shelf—yea, even on the "patent medicine" shelf—there to cavort with Lyda Pinkham, old Mother Winslow, Mr. Hostetter and scores of other imps and impesses of the Realms of Darkness. We feel so sorry for the poor little can of salts. Poor, innocent, little thing placed there in such vile company without a chance to stay the mighty hand that places, and with such degrading associates and playmates, how can it hope to withstand the influences of its surroundings? How can the gentle, trusting, innocent help becoming corrupted and devilish? And the poor parent! How our heart aches for that poor father as he sits helpless watching his dear baby child, his sweet little can of epsom salts go to the devil!

The recipient intended to ignore the letter, the folly of a personal reply being only too clear. But his colleague in this discussion, Dr. Wyant, thought differently about it and asked permission to write an answer. The following is a copy of that answer.

Winfield, Kansas, Dec. 4, 1907.

Dr. W. C. Abbott, Chicago, Ill.

Dear Doctor:—Your letter of the 29th ult. to Dr. Lloyd A. Clary of this city this day handed me for my consideration.

The article referred to was read at the Cowley County Medical Society in September, and was freely discussed by different members of the society, myself opening the discussion. In your letter you say you would be exceedingly obliged for any indication to you of any means of preventing the druggist putting proprietaries like "Abbott's Saline" on same shelves with patents after they have paid for the same. I will very gladly suggest a remedy, one most agreeable to the honest druggist and the profession. Put your "Saline Laxative" up in a container that has no name of Mfrgr. stamped thereon also without wrapper containing a lot of advertising such as is used by all quack medicine houses. A label containing contents and adult dose is all that is required for any druggist to know. If you have anything further to say, say it to the profession and not to the public as is done by patent medicine houses through Almanacs.

If the above rule is followed out the proprietaries that have real merit will be found on the druggist dispensing shelves and not among the worthless patents. In a short time the united profession will refuse to use or prescribe any remedy put up in "patent medicine" fashion. I have long ago refused any retail man the right to leave on my desk remedies so put up. I am for advancement all along the line but can see no good in names of manufacturers or remedy blown in container and the same put in pasteboard coverings, or with a wrapper, containing a lot of advertising matter such as is used by quack patent houses for the druggist to counter prescribe and the laity buy and use at random. I would like, Doctor, for you to publish a copy of your letter to Dr. Clary and my answer to same in your January Journal.

Remedies put up as you put up your "Saline" is either for the profession or the patent trade. Which, Doctor? Truly yours,

O. B. Wyant, Treasurer Cowley County Medical Society.

Now the above was written and mailed Dec. 4, 1907, plenty of time to have been published in the January number of Doctor Abbott's Journal, the American Journal of Clinical Medicine, but we note that it did not appear. This we expected. What is more significant, however, is the fact that absolutely no attention was paid



to Dr. Wyant's letter, at least no answer has been received. If Dr. Abbott wished to do the right thing with his "greatest human house cleaner on earth," he certainly would have indicated his intention at least by this time.

The truth of the matter is we are chumps—fools would perhaps be a better word—to give support to a preparation such as the above. We, the physicians of America, who have used and prescribed this stuff, are primarily to blame. If we hadn't used it to begin with, the manufacturer would not have continued putting it out. But now that the best element of the profession has awakened from its lethargy and demanded a change in the proprietary business, an essential change and one to benefit all honest men, now that this has been demanded there is no shadow of excuse for the continuance of the policy shown in the exploiting of Abbott's Saline Laxative. Especially should there be no such "patent medicine" methods from a house whose head has always proclaimed such friendship for the doctor. "Our work is for the doctor." "For the doctor as against any power in creation or any combination or movement that may be used to his detriment." "We have no secrets whatever from the profession." A few samples of the sayings of Abbott. If Dr. Abbott means what he says he should hasten to "get right" with his Saline Laxative, tear off the "patent medicine" literature around the can, wipe out the name of manufacturer from its boldly prominent place in raised letters, and put out a preparation we physicians can prescribe without the fear of the patients' returning to the drug store for pounds more in the belief that we are helping the nostrum business.

Now, just a word more. Dr. Abbott repeatedly evades the issue in replying to the criticism on his products as shown, for instance, in his answer to various recent attacks which he makes in the advertising columns of the St. Louis Medical Review, December, 1907. He claims the Journal A. M. A. is unjustly prosecuting him. We don't believe a word of it.

And right here we wish to say that there is no personal attack, no personal animosity, nothing but a desire for fair play and fair dealing in this communication. We would just as willingly attack any other large or small manufacturing pharmacists who pretend to be ethical in all things and in all their dealings with the medical profession and yet are unethical in some feature of their business. Just as an example of the latter and to show we "play no favorites" we may mention John Wyeth & Brother, Inc., an old pharmaceutical

house with a record of many years of honest dealing, and yet they put up their preparations in bottles of characteristic shape with their name blown in the side and on some of their products the amount of gratuitous reading matter is evidence of lack of due regard for the physician and of ethical practices generally. As glaring examples of their products thus supplied with circulars or uncalled for instructions to the public may be cited the following: Sevetol—Wyeth's Granular Effervescent Sodium Phosphate and Wyeth's Compressed Effervescent Lithia Tablets.

Feb. 1, 1908.

Since the completion of the above, the following letter reached Dr. Wyant:

Chicago, Ill., Jan. 8, 1908.

Dr. O. B. Wyant, Winfield, Kans.

My Dear Doctor:—This is a delayed reply to yours of Dec. 4th. I am very glad this matter has come up. If there is anything in the heart of the medical profession against us we want to know it before or as soon after it appears as we possibly can. No one knows just how they look to others until they can see themselves through the eyes of others, as we do in this instance.

There is nothing on earth further from our minds than to trade on the doctors' influence and reputation with the laity, and it would seem that our record with the medical profession and our fight for them, which we have waged unceasingly against great odds for many years, should be evidence enough that we are square.

There is no name of manufacturer stamped on our Saline Laxative package, and usually, if not always, it is put out with the label hooks, just tipped at the corner to hold it from turning, so that the druggist can remove it easily, and the dosage with minor suggestions as to the time for use which we find necessary even in the doctor's case, is all of consequence that the label suggests.

As to where the druggist shall keep Saline Laxative or similar preparations, that certainly is up to him, and really, when you come down to it, a simple laxative could scarcely be held to be a dispensing preparation anyway, to be found only on the druggist's dispensing shelves. Take a look at any druggist's and see if I am not correct.

I agree with you exactly as to the matter of proprietaries or remedies of any kind being put out for dispensing in the original containers with the name of the manufacturer, or the preparation (which is one worse) blown or stamped on the package. You will not find that the case with our preparations excepting such as are put up to be dispensed on count; and then, again, you know ours are largely dispensed by the doctor anyway, so that he can control the situation exactly.

I shall be very glad to publish this correspondence and will

do so if you will kindly answer my letter in spirit.

By today's mail I am sending you a complimentary package of Saline Laxative which I have sent for to the manufacturing department and secured while dictating your letter, and you will find everything relative to it exactly as I say. Not only this, but unless you know it through experience to be a first-class preparation, try it and you will find it so.

If you will go over this package carefully, Doctor, noting that what I have said is true, realizing the difficulty of pleasing everybody and taking into consideration just what I have said, I am sure you will agree with me that it is not an unethical package. Should it be so considered by any large number of the profession (and I will ask the question in connection with the publication of this correspondence), I will change it at once.

With regards, thanking you for your courtesies and awaiting your pleasure, I am

Sincerely yours,

W. C. Abbott.

The following is Dr. Wyant's reply, written with Dr. Clary's approval:

Winfield, Kans., Jan. 14, 1908.

W. C. Abbott, M. D., Chicago, Ill.

Dear Doctor:—Your delayed reply of the 8th inst. to my letter to you of the 4th ult. received.

I fail to see wherein you have answered my former letter. The facts are, your Saline is put up in a container that has stamped on the lid marks of identity as to the manufacturer. The advertising matter wrapped around the container is all that could be desired for any patent.

Further, your Saline put up is being put out by the counter prescribing druggist and bought by the laity as a patent.

As in my first letter to you, I again say remedies put up as you put up your Saline are either for the profession or patent trade. Which, Doctor?

I will look for a reply from you by the 25th inst., as I am preparing an article along the same line as above and hope to have your answer before completion of same.

Yours for advancement,

O. B. Wyant.

We received in reply a letter from Dr. Abbott dated Jan. 18, 1908. This was a very rambling, evasive letter, containing many uncalled for slurs and sarcastic remarks, with the evident intention of obscuring the point at issue. Dr. Abbott seems to think that we are attacking his products exclusively and without cause. This is not the case. We are simply, as stated above, opposed to the method employed in exploiting his "Saline Laxative."

It is not necessary to state on the label around a can of effer-

vescing "Epsom Salts" that it is to be used: "At all ages and in all conditions where a cooling, soothing, anti-acid, anti-ferment laxative or cathartic is needed."

"Acting as above, in the hands of the physicians, it is a prompt and sure relief for most forms of diarrhoea, constipation, foul breath and other conditions due to derangement of the digestive functions," that the medical profession may know how to use salts.

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# THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

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Entered at the Postoffice at Columbus, Kansas, as Second Class Matter.

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CHAS. S. HUFFMAN, . . . . . EDITOR

J. E. SAWTELL, }  
GEO. H. HOXIE, } ASSOCIATE EDITORS

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Subscription rates: \$2.00 per year; 20c single copy. Advertising rates furnished promptly on application.

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**Meeting of State Society.** The Kansas Medical Society will meet at Iola May 6, 7, and 8, 1908.

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Dues for the year 1908 should be paid at once, so that all members may receive their 1908 membership card.

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The Kansas Medical Society has always contended that medical professions should recommend the candidates for places on the State Boards of Health and Registration and Examination, and that it should not be left to political pull. At last we have a governor who has granted us this right. His letter is as follows:

Topeka, February 24, 1908.

Chas. S. Huffman, Columbus, Kans.

My Dear Friend:—I have already decided to await the action of the Kansas Medical Society before making the appointments to which you refer, and have so informed parties interested. With best wishes, I am Cordially yours,

E.W. Hoch.

—————

The following is a good average of the advertising adopted by the druggists in many places in this state. A physician who resides in the town where the druggist lives who runs this advertisement, writes that all the resident physicians do prescription work. This kind of advertising is what will eventually cause physicians to furnish their own medicines.

## WHERE FORETHOUGHT PAYS.

“As an apothecary in 34 years here we know we have saved many a family expense and anxiety by suggesting remedies for common ailments that are apt to be neglected and grow serious and expen-

sive afterwards.

"These medicines we have yet, and increased experience. Call in and let us tell you about them.

"It is easier and much safer to take home a bottle of croup medicine than to face a cold wind to town at night after the need comes, or perhaps from being neglected for hours necessitates the calling of a physician or EVEN WORSE.

"It is easier and much cheaper to have medicine on hand for earache, toothache, stomach and bowel trouble, coughs and colds, roughness of hands, tired and aching feet, and all such common ailments. As we said before, our long experience enables us to give you valuable service along these lines at a trifling cost to you. We are not a policeman, but we invite you to tell us your troubles, anyway."

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#### Obituary.

Dr. H. E. Hastings of Olathe, died Feb. 13. 1908. Dr. Hastings was a member of the Johnson County, and State Medical Societies. He always took an interest in everything that stood for the advancement of medical science and the medical profession.

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#### Obituary.

Dr. Francis M. Owens of Argonia, died Feb. 17, 1908, of pneumonia. He had lived in Argonia since 1902, was president of Sumner County Medical Society in 1907. He took an active interest in the welfare of his home town. He was a member of the Elks and a thirty-second degree Mason. A widow and four children survive him.

THE JOURNAL OF THE  
**NEWS AND NOTES.**

The Central Committee of the International Congress on Tuberculosis has announced the offer of the following prizes:

1. A prize of \$1,000 is offered for the best evidence of effective work in the prevention or relief of tuberculosis by any voluntary Association since the last International Congress in 1905. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

Evidence is to include all forms of printed matter, educational leaflets, etc.; report showing increase of membership, organization, classes reached—such as labor unions, schools, churches, etc.; lectures given; influence in stimulating local Boards of Health, schools, dispensaries, hospitals for the care of tuberculosis; newspaper clippings meetings held; methods of raising money; method of keeping accounts.

Each competitor must present a brief or report in printed form. No formal announcement of intention to compete is required.

2. A prize of \$1,000 is offered for the best exhibit of an existing sanatorium for the treatment of curable cases of tuberculosis among the working classes. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

3. A prize of \$1,000 is offered for the best exhibit of a furnished house, for a family or group of families of the working class, designed in the interest of the crusade against tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award. This prize is designed to stimulate efforts toward securing maximum of sun-light, ventilation, proper heating, and general sanitary arrangement for an inexpensive home. A model of house and furnishing is required. Each competitor must present a brief with drawings, specifications, estimates, etc., with an explanation of points of special excellence. Entry may be made under competitor's own name.

4. A prize of \$1,000 is offered for the best exhibit of dispensary or kindred institution for the treatment of the tuberculosis poor. In addition to the prize of \$1,000, two gold medals and three silver

medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

5. A prize of \$1,000 is offered for the best exhibit of a hospital for the treatment of advanced pulmonary tuberculosis. In addition to the prize of \$1,000, two gold medals and three silver medals will be awarded. The prize and medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management and results obtained. Each competitor must present a brief or report in printed form.

6. The Hodgkins Fund prize of \$1,500 is offered by the Smithsonian Institution for the best treatise that may be submitted on "The Relation of Atmospheric Air to Tuberculosis."

The detailed definition of this prize may be obtained from the Secretary-General of the International Congress or Secretary of the Smithsonian Institution, Chas. D. Walcott.

7. Prizes for Educational Leaflets:

A prize of \$100 is offered for the best educational leaflet submitted in each of the seven classes defined below. In addition to the prize of \$100, a gold medal and two silver medals will be awarded in each class. Each prize and medal will be accompanied by a diploma or certificate of award.

Competitors must be entered under assumed names.

A. For adults generally (not to exceed 1,000 words).

B. For teachers (not to exceed 2,000 words).

C. For mothers (not to exceed 1,000 words).

D. For in-door workers (not to exceed 1,000 words).

E. For dairy farmers (not to exceed 1,000 words).

F. For school children in grammar school grades (not to exceed 500 words).

In classes A, B, C, D, E, and F, brevity of statement without sacrifice of clearness will be of weight in awarding. All leaflets entered must be printed in the form they are designed to take.

G. Pictorial booklet for school children in primary grades and for the nursery.

Class G. is designed to produce an artistic picture-book for children, extolling the value of fresh air, sun-light, cleanliness, etc., and showing contrasting conditions. "Slovenly Peter" has



been suggested as a possible type. Entry may be made in the form of original designs without printing.

8. A gold medal and two silver medals are offered for the best exhibits sent in by any States of the United States, illustrating effective organization for the restriction of tuberculosis. Each medal will be accompanied by a diploma or certificate of award.

9. A gold medal and two silver medals are offered for the best exhibit sent in by any State or Country (the United States excluded), illustrating effective organization for the restriction of tuberculosis. Each medal will be accompanied by a diploma or certificate of award.

10. A gold medal and two silver medals are offered for each of the following exhibits: each medal will be accompanied by a diploma or certificate of award; wherever possible each competitor is required to file a brief or printed report:--

A. For the best contribution to the pathological exhibit.

B. For the best exhibit of laws and ordinance in force June 1, 1908, for the prevention of tuberculosis by any State of the United States. Brief required.

C. For the best exhibit of laws and ordinances in force June 1, 1908, for the prevention of tuberculosis by any State or Country (the United States excluded). Brief required.

D. For the best exhibit of laws and ordinances in force June 1, 1908, for the prevention of tuberculosis by any municipality in the world. Brief required.

E. For the society engaged in the crusade against tuberculosis having the largest membership in relation to population. Brief required.

F. For the plans which have been proven best for raising money for the crusade against tuberculosis. Brief required.

G. For the best exhibit of a passenger railway car in the interest of the crusade against tuberculosis. Brief required.

H. For the best plans for employment for arrested cases of tuberculosis. Brief required.

11. Prizes of two gold medals and three silver medals will be awarded for the best exhibit of a work-shop or factory in the interest of the crusade against tuberculosis. These medals will be accompanied by diplomas or certificates of award.

The exhibit must show in detail construction, equipment, management, and results obtained. Each competitor must present a brief or report in printed form.

The following constitute the Committee on Prizes:

Dr. Charles J. Hatfield, Philadelphia, Chairman.

Dr. Thomas G. Ashton, Philadelphia, Secretary.

Dr. Edward R. Baldwin, Saranac Lake.

Dr. Sherman G. Bonney, Denver.

Dr. John L. Dawson, Charleston, S. C.

Dr. H. B. Favill, Chicago.

Dr. John B. Hawes, 2nd., Boston.

Dr. H. D. Holton, Brattleboro.

Dr. E. C. Levy, Richmond, Virginia.

Dr. Charles L. Minor, Ashville, N. C.

Dr. Estes Nichols, Augusta, Me.

Dr. M. J. Rosenau, Washington.

Dr. J. Madison Taylor, Philadelphia.

Dr. William S. Thayer, Baltimore.

Dr. Louis M. Warfield, St. Louis.

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### **The Red Cross Thrown Open.**

The government has decided to throw open the American National Red Cross to general membership, and already applications for enrollment are pouring in. Under the plan every good American citizen—man, woman or child—is eligible to membership.

On application to Edward R. Johnston, National Registrar of the Red Cross, 341, War Department, Army and Navy Building, Washington, D. C., the applicant's name will be enrolled, a badge of membership forwarded, and the Cross Red Bulletin will be sent regularly for one year.

Every candidate should forward one dollar with application, to cover enrollment and necessary expenses.

Information relative to the organizing of Red Cross Circles will be forwarded by the National Registrar upon request.

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### **Philadelphia Medical Schools and the U. S. Pharmacopoeia.**

At an informal conference called by Prof. Joseph P. Remington, of the teachers named below in the medical schools of Philadelphia, the following resolution was passed:

Resolved, that it is of the utmost importance for accuracy in prescribing, and in the treatment of disease, that students of medicine be instructed fully as to those portions of the United States Pharmacopoeia which are of value to the practitioner, and that

members of the medical profession be urged to prescribe the preparations of that publication, and further, that this resolution be forwarded to the Medical and Pharmaceutical Journals, and to the teachers of medicine and therapeutics in the United States.

James Tyron, M. D.

Seneca Egbert, M. D.

John H. Musser, M. D.

M. C. Thrush, M. D.

John Marshall, M. D.

James Wilson, M. D.

Horatio C. Wood, Jr., M. D.

E. Q. Thornton, M. D.

H. A. Hare, M. D.

John V. Shoemaker, M. D.

J. W. Holland, M. D.

I. Newton Snively, M. D.

Alfred Stengal, M. D.

J. M. Anders, M. D.

David L. Edsall, M. D.

S. Colis Cohen, M. D.

February 3, 1908.

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**American Medicine** has now passed out of the hands of Dr. George M. Gould and his staff. Dr. Frank Clark Lewis is the new managing editor. The Journal will continue to be a monthly issue at and is Philadelphia.

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Dr. L. V. Sams of Rock Creek, who has served so efficiently as Secretary of Jefferson County Medical Society has sold his practice going to take a post graduate course in New York.

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The Hodgkins Fund Prize of \$1,500 is offered by the Smithsonian Institution, Washington, D. C., in accordance with the following announcement:

In October, 1891, Thomas George Hodgkins, Esquire, of Setauket, New York, made a donation to the Smithsonian Institution, the income from a part of which was to be devoted to "the increase and diffusion of more exact knowledge in regard to the nature and properties of atmospheric air in connection with the welfare of man."

In the furtherance of the donor's wishes, the Smithsonian Institution has from time to time offered prizes, awarded medals, made grants for investigations, and issued publications.

In connection with the approaching International Congress on Tuberculosis, which will be held in Washington, September 2, to October 2, 1908, a prize of \$1,500.00 is offered for the best treatise that may be submitted to that Congress "On the Relation of Atmospheric Air to Tuberculosis."

The treatise may be written in English, French, German, Span-

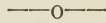
ish or Italian. They will be examined and the prize awarded by a Committee appointed by the Secretary of the Smithsonian Institution in conjunction with the officers of the International Congress on Tuberculosis.

The right is reserved to award no prize if in the judgment of the Committee no contribution is offered of sufficient merit to warrant such action.

The Smithsonian Institution reserves the right to publish the treatise to which the prize is awarded.

Further information, if desired by persons intending to become competitors, will be furnished on application.

Charles. Walcott, Secretary Smithsonian Institution,  
Washington, Feb. 3, 1908.



### SOCIETY NOTES.

Editor Journal:—

Franklin County Medical Society at its annual meeting elected the following officers:

C. W. Hardy, Ottawa, President.

V. E. Lawrance, Ottawa, Vice President.

J. M. McWharf, Ottawa, Secretary and Treasurer.

This our fifth annual banquet was well attended. H. W. Gilley, retiring president, acted as toast master. The following responded to toasts that had been assigned them:

J. M. McWharf, Ambition.

V. E. Lawrance, The general Practitioner.

J. R. Lytle, Notes not Negotiable.

R. S. Black, Pigs in Clover.

H. W. Wright, Gasoline.

A general good time followed in which all participated.

Regular meetings the last Wednesday night of each month.

### PROGRAM—1908.

MARCH 25. Influence of Mind Over Matter in Health and Disease, Dr. Josephyne E. Davis.

April 29. Man Abnormal, Dr. J. M. McWharf.

May 27. Anesthetic, Preparation for, Choice of, and Method of Administration, Dr. E. B. Gossett.

June 24. Tetanus, Dr. F. C. Herr.

July 29. Enterocolitis, Acute and Chronic, Dr. J. R. Lytle.

August 26. Obstetrical Emergencies and their Treatment, Dr. Geo. W. Davis.



September 30. Legal and Moral Responsibilities of the Physician.

(Should Professional Confidence Always be Inviolable?) Dr. H. W. Gilley.

October 28. Scarlatina, Dr. V. E. Lawrance.

November 25. Chronic Nephritis, Parenchymatous and Intestinal, Dr. H. B. Johnson.

December 30. The Best Cardiac Remedies, Differential Indication for Their Use, Dr. W. L. Jacobus.

January, 1909. Annual Banquet. Address by the President, Dr. C. W. Hardy.

Alternates.

Therapeutics, Non Medicinal, Dr. H. L. Kennedy.

Static Electricity in Treatment of Nervous Disorders, Dr. A. Haggart.

Smallpox, Dr. James Ball.

The Obligation of the Physician to his Profession and Clientage, Dr. R. S. Black.

Any of the medical fraternity in our city on night of meeting are cordially invited to meet with us.

J. M. McWharf, Secretary and Treasurer.

### Montgomery County.

Independence, Kans., Feb. 13, 1908.

Editor Journal: The Montgomery County Medical Society met Tuesday, Feb. 11, 1908, at 3 p. m., in Independence, with a goodly number of the members present.

Papers were read by Drs. J. A. Pinkston, of Independence, on Infantile Feeding, and by J. T. Davis of Independence, on Sciatica. Dr. A. W. Evans of Independence, was made a member of the Society upon application on ballot. The application of Dr. F. W. Duncan of Coffeyville, was presented for membership, and referred to the Board of Censors. The membership now numbers 39, and there are a few more in the county who have asked for application blanks, but have not been furnished as I have no more. Will you kindly send me blanks.

Our Society will meet hereafter on the second Tuesday of each month at 7:30 p. m., in Independence, Kans. Very truly yours,

W. C. Chaney, Secy.

**Western Medical Society.**

You are cordially invited to attend the meeting of the Western Kansas Medical Society to be held at Colby, Kans., Wednesday, March 18, 1908.

This meeting will take the place of the January and April meeting. Members are requested to bring their wives. All members having clinical material of interest are earnestly requested to present it at this meeting. Every member is especially requested to be present and visiting physicians from other societies will be accorded a cordial welcome. It is our intention to make the Northwestern Kansas the best medical organization in the state and we need the encouragement of your presence and the benefit of your discussions. Don't be a 'has-been,' a "foggy" or a "back number," but come in and let us help each other. If you can't come, don't forget to send in your dues. Those on the program will confer a favor by sending in their papers to the president or secretary, in order that they may be read in case the author is unable to be present.

**MORNING SESSION.**

10:30 Paper, Empyema, Dr. V. C. Eddy, Colby. Discussion by Drs. Gulick and Winslow.

11:15 Paper, Pneumonia With Special Reference to its so called Specific Treatment, Dr. F. H. Smith, Goodland. Discussion by Drs. Blake and Mirell.

11:30 Business Meeting.

12:30 Intermission.

**AFTERNOON SESSION.**

2:00 Paper, Acute Parenchymatous Nephritis, Dr. E. D. Beckner, Hoxie. Discussion by Dr. Beaver and Marsh.

2:45 Paper, Tuberculosis, Dr. I. B. Parker, Hill City. Discussion by Drs. Lowis and McNoughton.

3:30 Paper, Chronic Myofibrosis. Some remarks on its Pathology Treatment and its Relation to the Stokes-Adams Syndrome, Dr. F. A. Carmichael, Goodland. Discussion General.

4:00 Clinic.

**Shownee County.**

March 12, 1908.

Editor Journal:—The March meeting of the Shawnee County Medical Society was an exceptionally good one. The following clinical reports were presented by Dr. W. A. Wehe. A case of Uraemia with symptoms resembling meningitis, by Dr. C. M. Hen-

sley. Chronic Otitis Media, by Dr. W. D. Stows. A report of a successful operation, which restored complete function to a fractured elbow after its loss by reason of faulty union from fracture. Dr. S. J. Crumbine gave the Society a good paper on the work of the State Board of Health. He took up the question of tuberculosis in dairy cows and milk. He dwelt on the importance of the milk supply to the general health, and called attention to the number of cases of tuberculosis originating from the intestinal tract.

Dr. Schenlaber, State Veterinary, was present, and spoke on the subject of "Criminal Tuberculosis" in discussion of Dr. Crumbine's paper.

A committee consisting of Drs. Crumbine, Powell and Barns was appointed to investigate local conditions as regards tuberculosis, and make recommendations to the society as to what preventive measures could be taken by the society. J. B. Tower, Secy.

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### ABSTRACTS.

#### **A New Method of Testing the Functions of the Digestive Apparatus.**

Einhorn (Therapeutic Gazette, January, 1908) submits a method for investigating the functions of the intestinal tract, the principle of which is the administration of test substances with the food and observation of the effects of the digestive fluids upon these substances.

Practically this test is made as follows: Patients are given in a gelatin capsule a string of beads with the following substances attached thereto: catgut, fish-bone, mat, thymus, potato, mutton fat. After administering the capsule, every stool is examined with the stool-sieve until the bead-string has been recovered. If diarrhoea is present the sifting may not be necessary, as the bead-string can readily be seen (usually at the bottom of a glass vessel.)

Under normal conditions the bead-string appears after one or two days. It is then rinsed in cold water and examined. If digestion is normal we find that catgut, meat, and potato (except the skin) disappear entirely, thymus and fat almost entirely, whereas the fish-bone usually disappears, but occasionally it may be present.

The nuclei of the thymus always disappear. In pathological conditions deviations from the normal are observed, not only in regard to the time of recovery of the beads (disturbances of motility), but also in regard to the presence of the food substances (disturb-

ances of the digestive function.)

The author divides his cases of intestinal digestive disturbances into two groups:

1. Those of pure nervous intestinal dyspepsia.
2. Those of genuine intestinal dyspepsia.

In that great class of cases of intestinal dyspepsia, in which the starch digestion alone is disturbed, Taka-Diastase (Takamine) has proved of especial value.

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**Twenty Hospital Cases.**

I have used the H-M-C anesthetic successfully in twenty cases, full reports of which I have kept as they were all hospital cases.

J. B. Wright, M. D. Trenton, Mo.

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**Used in Miscarriage—Just What was Wanted.**

I find your H-M-C hypnotic anesthetic just what I have wanted for some time, and will keep a supply always on hand.

In miscarriage where the placenta must be removed under anesthesia they are the very thing and relieve the operator of the worry of chloroform or ether. I believe them superior to the morphine and atropine hypodermic as more lasting and certain in effect.

Dr. A. D. Barnett, Guilford, Mo.

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**Greatest Accessory of Modern Times.**

I used your H-M-C tablet in operation for ventral hernia. A previous operation failed to get union. I handled the intestines for a lesion and in closing the wound lapped the muscles well and used strong staple sutures after the Mayo method for umbilical hernia. I gave one tablet two and a half hours before operating, repeated in a half hour. During one hour's work she inhaled only twenty drops of chloroform, and could have done without that; especially if I had given the third tablet. This combination is destined to be one of the most important accessories to capital surgery in modern times.

J. M. Inge, M. D., Denton, Texas

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# THE JOURNAL

OF

## THE KANSAS MEDICAL SOCIETY

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Volume VIII.

APRIL 1908.

Number 4

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### **INJURIES TO THE INTRA ABDOMINAL VISCERA, DUE TO BLOWS, KICKS, CRUSHES AND LIKE ACCIDENTS.**

By DR. E. E. LIGGETT, Oswego, Kansas.

The literature of gun shot and stab wounds of the abdomen is voluminous. The cases recorded are numerous and some points in reference to this class of injuries seem well settled. The first point so settled is that about 95 per cent of the penetrating wounds of the abdomen result in serious visceral injury. The second is that in every case the abdomen should be opened as soon after the receipt of the injury as a surgeon competent to repair the damages can be had. The third is that the mortality is much greater if the operation is delayed a few hours.

The literature of intra-abdominal injuries due to kicks, blows, crushes and similar accidents is comparatively scanty, and the recorded cases are comparatively few. Those that are recorded show that an apparent trivial blow may, and often does, cause a fatal injury. The writer has come in contact, through consultation, with two such cases recently, and has heard of three more in the near neighborhood. Observation and common experience indicate that such accidents are of more frequent occurrence than gunshot or stab wounds. If so why then is their literature so scanty and their records so few? Both the cases I saw in consultation were moribund; both died of general peritonitis, in neither was an autopsy held; there was nothing spectacular nor of special interest in either case, so they were not reported. It is quite probable that the majority of such cases are not reported for the same or similar reasons.

Read before the Kansas Medical Society at Kansas City, May 10, 1907.

ons, especially as one is likely to report only the favorable cases or those that recover under the treatment used. The mortality in the recorded cases is large, much larger than in the gun shot and stab wound cases as now treated. But in the case of either gun shot or stab wound, however trivial they may seem, a doctor is sent for and if the wound has penetrated the abdominal cavity, he immediately calls the surgeon and tells the patient or friends the only hope of saving the life of the patient is by an early operation, which is usually promptly accepted and is done at once with increasingly good results and lessened mortality. When the injury is a blow on the abdomen the hollow visera, usually the colon or stomach, may be bursted or torn; the solid viscera may be split, torn or bruised; or a sub-peritoneal haematome may be formed, to later result in an abscess or in gangrene of the parts supplied by the injured blood vessel. In these cases, unlike the gun shot or stab wound cases, the physician even may not be called for some time, and if he is called promptly he often finds the patient and his friends loth to believe the injury very serious. Hoping the patient is not much hurt they hesitate to call a surgeon for a day or two or until the favorable opportunity has passed. The doctor, too, often advises the same thing because he has no very clear idea as to the extent of the internal injury and unfortunately as yet surgeons have not given him any reliable guides or pointed out to him early symptoms indicating the imperative need for an immediate laparotomy.

An early operation on a rent stomach or bowel, or a ruptured spleen or liver, or a torn blood vessel wound lessen the mortality of such an accident to the same degree that it has done in cases of gun shot or stab wounds. But if the operation is delayed until general peritonitis has developed from the infection of a leaking bowel or until the patient has bled nearly to death from a ruptured liver or spleen, there is little use of doing an operation at all.

What signs are there to guide the physician in determining the need for operation? No such signs are as yet recognized or tabulated, and until they are definitely determined we may expect the general practitioner to continue to wait for signs of peritonitis to develop before calling the surgeon to take charge of the case.

In depressed fracture of the skull the signs are usually obvious and the surgeon is called sufficiently early. In traumatic-meningeal hemorrhage the general practitioner has well defined rules to guide him in making a diagnosis and calling a surgeon. In appendicitis and other surgical diseases it is the same. But no such rules are

available to guide one in abdominal injuries. In penetrating wounds of the abdomen the fact of penetration is usually the sole guide depended upon in reaching a conclusion to do an abdominal operation and because this one sign is so conclusive and imperative it may be that others not so potent have been overlooked, though present. It is the sole purpose of this paper to call the attention of this body of medical men, physicians and surgeons alike, to the hiatus in our knowledge of the early symptoms of grave abdominal injuries, and it is the hope of the essayist that discussion of the subject will enable one to formulate a rule or guide in determining the need for early operative interference in such cases.

Text books on medicine give nothing on the subject, and text books on surgery give little more. Sheldon on Indications for Surgical Operations (just from the press) says "There are no signs or symptoms of extensive injury to the viscera that are absolutely reliable. \* \* \* Rigidity of the abdominal muscles associated with a considerable degree of shock presents an indication for operation." Dennis' System of Surgery says: "The severity of the force (of the blow), the location of the contusion, the local tenderness and the general shock manifested" must be considered.

After quite a thorough search through a considerable number of text books on surgery the two quotations given are the most definite statements found, though Erichson, an old author, very neatly sums up the whole matter by saying: "The symptoms of an internal abdominal injury are often extremely equivocal."

In recent medical magazines there are mentioned numerous and varied symptoms, the most reasonable and important probably being found in a list which includes shock, nausea, vomiting, pain, thoracic breathing, rigidity of abdominal muscles, tenderness, tension, tympany and local dullness. It would seem that if there has been a blow or kick on the abdomen followed by pain that continues more than an hour and is accompanied by rigidity of the abdominal muscles an exploratory opening of the abdomen is justified. If the pain and rigidity are accompanied by tenderness and shock with nausea or vomiting and acceleration of the pulse the operation is imperative. Cases not operated on are lost. At present the mortality is 75 to 80 per cent. When operated early the mortality will be much less.

#### DISCUSSION.

Dr. Sheldon:—In the book to which Dr. Liggett refers—Indication for Surgical Operations—the statement is mentioned that "There is no signs or



symptoms of extensive injury to the viscera that are reliable." Most anyone can diagnose a rupture of the bladder; few, if any of us are able to diagnose with certainty a rupture of the intestine. In a head injury, if we have a patient going into a decline, it means hemorrhage in 99 cases out of 100. If he recovers from the primary shock; and, instead of improving, begins to decline, it means hemorrhage and is a positive indication for operative treatment. The thing is different in rupture of the intestine. There is no positive symptom. There have sometimes been two or three bowel movements, and still the bowel has been ruptured. If, when the abdomen is opened, one should find one rupture, one should not be satisfied with that and close the abdomen without making a careful search for more. Cases have been found where there have been as many as six due to traumatic injury. The violence of the blow may also be an aid to tell whether or not we have a rupture. A person hit with a heavy instrument would be much more likely to be ruptured than one hit with a lighter one. While this is a point to be considered, it is probably too indefinite to base a conclusion on.

Dr. Shannon:—I do not know that I could point to any certain points of diagnosis. I have one case which I wish to report. The man was hit on the abdomen, causing a severe internal injury. A diagnosis of rupture of the bowel into hernia also was made. Operation was positively refused. After sometime, he consented to operation. Just to emphasize the fact that early operation is the only successful one, I wish to tell the result. We found the hernial sac full of fecal matter; and, general sepsis had already begun.

Dr. Jones:—I do not know whether or not the essayist brought out one point in determining the time for operating. That is, that in most cases there is paralysis of the bowel. That gives you a safe time for operation. If you can get in and there has not been too much hemorrhage. If you can get into the bowel within six hours of the accident, you can get in before any peristaltic action has caused any harm. Even a small wound will make such complete paralysis that it will pour out very little fecal matter. In the large bowel, it pours out none. The contents of the small bowel are always liquid so that it pours out more. Many good surgeons fail to take this into consideration. As a matter for diagnosis, where you have an abdominal injury of any kind where the force of the blow has been apparently sufficient to produce a rupture of the small or large bowel, it should always be suspected. Where you have a symptom of shock that cannot be accounted for by the injury present, internal hemorrhage is again to be suspected. If within the period of safety, I always say "Open the abdomen."

Dr. Blasdel:—There is one point: I want to ask Dr. Liggett a question. He said 75 to 80 per cent of the cases died. I want to ask whether he meant to say 75 to 80 per cent of all those who had received an injury to the abdomen; or, of those who had suffered a torn viscera.

Dr. Liggett:—In answering Dr. Blasdel's question, I would say: All who have ruptured bowel, die. The mortality is 100 per cent. As to the force of the blow, one of our most eminent surgeons teaches that what appears to be a very trifling blow may, if the bowel is in a certain position,

rupture it. Of course, the hemorrhage from a torn liver or spleen gives a diagnosis that may be easily made. The surgeon is usually watchful for these things. But, it is especially in those cases of ruptured bowel that I want this society to throw light on. If we wait for recovery from shock, then they go into a decline; and, it is either hemorrhage or peritonitis. If we wait for this, we wait too long. The patient will die: and surgery will stand better in that neighborhood if we do not operate.

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“The practitioner should know something about pharmacy and its application to medicine as practiced. He should know, for instance, that there is a natural salicylate of sodium, an artificial one; and that the natural one costs about \$6.00 per pound, and the other about 50 cents, and that his patient will not get the \$6.00 variety unless he sees to it personally.”—Medical Sentinel, October, 1907.

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### **Asheville to Have an Ethical Pharmacy.**

A movement, headed by several well known physicians of Asheville, is being made to establish a drug store which will carry a complete stock of druggists' supplies and chemicals, and will make its specialty the filling of physicians' prescriptions, but will eschew, it is said, all “patent” or proprietary remedies.

## **SOME LESIONS OF THE MOTOR TRACTS OF CEREBRUM.**

By C. C. GODDARD, M. D., Leavenworth.

There is a very prevalent trouble, occurring in general practice, the gravity of which may be readily overlooked in one's daily work. The symptoms portraying the disease may be ascribed, especially at the terminal end, to some other trouble; as for example, heart failure, syncope, oedema of the lungs, etc. Certainly the death is due to the heart failure and the diagnosis so far is correct; but the origin of the heart failure should be inquired into a little more closely and not be let go at that as all sufficient for the time being; and as showing to the trembling public that everything is easy to our beloved family physician and they often wonder as did the rustics in the Vicar of Wakefield how "one small head could contain so much." The cause of many somewhat masked fatal classes of heart failure is due not to the heart itself, but to a disintegration of the motor areas of the brain. These cases often come to our notice from the fact that the patient is suffering intensely from a form of headache, intense in character and almost unrelievable by any known means of medication; pain is generally referred to the frontal region and is of the blinding and unbearable form. These headaches, if not ushered in by, are sooner or later followed by some form of loss of consciousness; either partial or complete, as an apparent syncope, or as is usually the case, an epileptiform seizure, lasting a few seconds; or a moment or two and which is succeeded by more or less paresis of motor nerves, on one or the other side of the body. Possibly only the center controlling the hand or arm, numbness of the foot or leg, or even a complete hemiplegia, but no matter what the form we are amazed at apparently complete restoration of function, either in a few moments, an hour, or at most a day or two. If the paresis is of the right side of the body we also have either paraphasia, or complete motor aphasia, these troubles also rapidly decline and apparent restoration takes place. I say apparent, but it is only apparent as sooner or later the injury takes its place and shows where some destruction really occurred. Soon after one of these attacks takes place the patient is noticed to drag one of the limbs in walking, or moves the arm, hand or foot slowly and somewhat awkwardly; even is seen to knead the afflict-

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ed member a good bit and is inclined to let the other or opposite limb do the work. At the same time they have some disturbance of sensation, shown by numbness and formication and these are probably the symptoms that cause the patient to favor and more or less pet the injured member, especially is this the case when the trouble is in the hand or arm.

These terrific headaches may be absent, extending over greater or less periods of time after the disease has set in; during these intervals the patient is more or less happy, though the headache may be in evidence more or less, causing the victim to run the gamut of all the doctors she knows and all of the sure cure headache medicines only to find in the end that her enemy is waiting and that there seems to be no relief for her sufferings. There is no doubt in my mind that many of the suicides amongst women between the ages of 20 to 40 is often due to the inability to stand the terrible agony with hope stricken from their lives and all due to an undiagnosed lesion of the part of the motor areas of the cerebrum. I do not mean to infer here that had a diagnosis been made that the end would have been any different, for it probably would not have been. In my opinion the headache is an important guide in these cases; so long as it intermits and the patient has some comfort between attacks the case is one that for the time being is fairly free from immediate danger. When it keeps up and has the train of symptoms, syncope, pileptiform seizures, etc. there is great cause for alarm, as the end may come very suddenly in any of those attacks. Have seen cases up and walk about not ten minutes before they were stricken by death. Albumin is at times present, but it is not a necessary symptom. The appetite between the attacks of pain and unconscious spells is of a voracious nature; bowels are generally sluggish and more or less constipated. The facial expression is quite characteristic and is very much changed from the normal, looking heavy and unresponsive, immobility of the facial muscles from the paralysis is of course to blame for this. Eyelids are generally puffy, pupils at times are irregular in size and respond slowly to stimuli of light and accommodation. One peculiar thing about these headaches is that they are generally accompanied by lethargy and at times even pronounced somnolence from which it is often difficult to arouse the patient.

These attacks are very marked toward the last, and in fatal cases pass often into coma which lasts for a few hours, the patient passing slowly but surely away without regaining consciousness.



The seat of the lesion is generally in the motor tract of the cerebrum and is characterized by its slow, insidious, but sure progress. In my experience it oftenest attacks the center governing the hand and forearm; then travels upward to the leg center and then proceeds slowly down and towards the vital centers of respiration and circulation and then the case has passed to the great unknown.

The treatment, to be of any avail, should be had early, and be rather of an expectant form, giving the brain as much absolute rest as possible, and in women to put a stop to child bearing.

We learn nothing much from the knowledge, but possibly if we have the true causation the future may hold some hope in store for the benefit of this peculiarly unfortunate patient; therefore it is simply my wish to direct attention to the trouble, knowing full well that our numerous up-to-date physicians will soon be able to point out to us how to obviate, even if not to stay, its dread progress.

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### **Doctors' Bad Hand Writing.**

Austria has an Imperial rescript against bad handwriting in prescriptions. A druggist is forbidden to file a prescription where the writing or any part of it, is not plainly written, or about the interpretation of which there is the slightest chance of doubt or misconception. The rescript went into immediate effect and there as said to be a remarkable improvement in the chirography of the doctors, which would go toward indicating great adaptability of effectation.—Illinois Medical Bulletin.

## CHOLERA INFANTUM.

By C. S. KENNEY, M. D., Norcatur.

Mr. Chairman and members of the Southwest Medical Association:—The subject which I am about to discuss, Cholera Infantum, is one of great importance, and I must beg to say that all contained in this paper is not original with me. On the contrary, it is gleaned from reading, talking with my medical associates, and from personal observation and experience; furthermore, I am not going to treat simple infantile diarrhoeas, but rather that very fatal malady, cholera infantum.

Before going further I must say I have but little patience with a man who claims that he has not lost a case in ten years, or words to that effect. The inference is that he has not had many cases or has made a mistake in diagnosis, yet now and then we hear of a case dying "with bowel trouble from teething." Strange as it may seem they all die during the warmer months of the year. If from teething why do not more die during the winter months?

Cholera infantum usually occurs in artificially fed children, or in those that have been weaned. The cause is most probably from bacteria, hence the prevalence in the summer months. The germs may produce it from without or there may be an auto-intoxication, the germs being normally present in the body, and under certain conditions, pathological properties or poisonous substances, may be produced by chemical changes in the food elements through the agency of the bacteria, which are habitually present.

Cow's milk, especially during the summer months, is teeming with bacteria and toxins may be produced before it has been sterilized. In such cases the toxins are not effected by the heat and several in the family using the milk may be simultaneously affected. The exact nature of the poison is not known, but it is probably some form of "acid intoxication."

The predisposing causes of cholera infantum are general and local. The general briefly are age, constitution, surroundings and feeding. Local, acute indigestion. The pathological findings are as follows: A catarrhal inflammation is present, extending throughout the entire length of the intestinal tract. The stomach is dis-

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Read before the Southwest Medical Association.

tended with gas and undigested food. The greater part of the intestinal tract contains a grayish white fluid with a mawkish odor. The whole condition is one of degeneration and decomposition, therefore to be of much value, an autopsy should be made soon after death, if not the changes come on so rapidly that the true pathological condition cannot be determined.

Cholera infantum is not the most frequently found of summer diarrhoeas; in fact it is a rare disease, and is most frequently associated with poor milk supply. The poison may develop before or after ingestion. The peculiar severe symptoms being due to the rapidity of absorption. The symptoms are primarily due to the effect on the heart and nerve centers and secondarily to the abstraction of water from the system. The disease is extremely rare in healthy children, and is present usually in those with a history of some previous intestinal disorder.

The symptoms develop very rapidly and in a very few hours the child is violently ill. In some cases fever precedes the attack of vomiting and purging, usually, however, the vomiting and purging begins first simultaneously or the vomiting preceding. The vomited material is composed of stomach contents, later serum, mucous and bilious matter. The stools are large, acid at first, later an alkaline fluid full of bacteria and of a pale green color—still later they become serous and do not stain the napkin, usually there is no odor, although there are times when they are very offensive. The sphincter is relaxed and the stools frequent, twenty to thirty and even fifty or more in twenty-four hours. The loss of weight is rapid, the fontanelles depressed, face pinched, angles of mouth drawn down and a peculiar pallor, best seen to be understood, overspreads the countenance. At first the child moans and is very restless—later dullness, stupor and coma or possibly convulsions come on in rapid succession. The temperature runs from 101 to 105 and 108, pulse fast and irregular, likewise the respiration. The belly is flattened and has a peculiar flabby feeling. The tongue is coated, yet some cases show a clean dry tongue. There is extreme thirst, yet the ingestion of water causes vomiting very often. Urine is scanty, none may be passed for 24 hours. Albuminuria is often present. No change may take place for 24 hours in the symptoms. In fatal cases there is hyperpyrexia, cold clammy skin, absence of radial pulse, stupor, coma, convulsions and death. The diarrhoea may continue to the end or both may cease before that time, the patient often passing into a condition resembling the algid stage of

cholera. In some cases there are marked nervous symptoms with a normal or sub-normal pulse with stupor following. Recovery may take place. This condition is called by some writers spurious hydrocephalus. Various explanations have been advanced for this condition, viz: cerebral anemia, cerebral hyoeremia, thrombosis, etc., but none are satisfactory, as no definite cerebral lesion can be found on post-mortem. Acute inanition and intestinal toxemia seem to be the best explanation of the condition. Sclerema may develop. This is always fatal. In case recovery takes place in cholera infantum all the symptoms abate and convalescence is very slow and relapses may be frequent.

This in brief comprises the symptoms and if once seen there can be no mistake. As one of my old college professors once said: "Gentlemen, if you once see a case of cholera infantum you will know it."

Prognosis. Of all cases seen fully two-thirds are fatal. In bottle fed infants under six months about 90 per cent succumb.

Treatment of attack is very unsatisfactory and the result depends upon the lightness of the attack more than upon the course of treatment. As has been noted, the case is one of profound intoxication and must be treated as such. Each symptom must be treated as the occasion arises. To the layman the diarrhoea is the paramount issue and must be stopped at once; to the physician there are many other symptoms that causes grief, ie: heart failure, convulsions, etc.

Much can be done in the way of prophylaxis. Every child should be breast fed unless there is a most excellent reason for weaning. When weaning becomes necessary the physician should lay down rigid rules for feeding the child. I have often made out a diet list for children. It makes me shudder to see children from 10 to 20 months old eating sauer kraut, cabbage, peas, beans, pickles, tomatoes, etc. No case of intestinal trouble should be overlooked. Watch the stools. It has been shown that the normal cow's milk stool contains characteristics which are the beginning of pathological conditions in a breast fed stool. This warns us to watch any indigestion and regulate the feeding. Usually no medicine is required, but the offending food element can be eliminated; the stool is the index. Briefly, the fat indigestion produces a large partly formed lumpy stool with a soapy look and rancid odor. It may be thin and green.

In a carbo-hydrate disturbance they are loose and foamy with



lots of mucous and germs may be present Both these conditions may be relieved by proper diet.

In complex types of indigestion a great deal of care and perseverance must be used to find out the disturbance and regulate the diet.

The more intelligent the nurse the more chance there is for bringing up an artificially fed baby. Country practitioners must not lose sight of this class of patients. No two children are exactly alike, so we cannot lay down any fast rules relative to feeding, but must make a study of each individual.

During the summer months less food and more water should be given. Food should be given at stated intervals and should be free from contamination, and the mother and nurse should be taught strict cleanliness of the bottles and feeding utensils. Simply washing and rinsing does not suffice, but a thorough scrubbing in hot soap suds should be practiced. The garments worn should be of light material and loose and the child given plenty of fresh air, preferably out of doors. The napkins should be removed often and cleansed and the patient kept scrupulously clean. If there is any doubt about the water or milk it should be sterilized.

The chief indications for treating a case of cholera infantum are:

- (1) To empty stomach and bowels.
- (2) To neutralize the effects of the poison.
- (3) To supply fluid and blood.
- (4) To reduce temperature.
- (5) To treat the symptoms as they arise.

Nature endeavors to empty the stomach and bowels at once, the colon should be irrigated by a high rectal tube. Lavage can be used in some cases, but generally it is impractical, in highly sensitive children impossible. A glass of normal salt solution if taken and then vomited will be of some service. All foods should be stopped at once. Calomel in 1-8 grain doses should be begun as soon as it can be retained and kept up for 12 to 15 doses. For the shock a hypodermic of morphine 1-50 gr. with 1-500 gr. of atropine to a child one year of age gives the best result. This may be repeated in one hour if necessary. At the same time a solution of normal salt solution injected into the cellular tissue will help the heart action and supply fluid to the body. The temperature is best treated by cold baths.

The injection of a starch solution into the lower bowels has its

advocates, but I fail to see the reasons for using it. Strychnine and brandy have a beneficial effect as stimulants and should be given with a free hand. Convulsions should be treated on general principles.

After the severe symptoms have subsided, I prefer to give some alkaline treatment, pancreatin, bismuth, solol and zinc-sulpho-carbolate. Food is given sparingly and the stools closely watched. Small doses of calomel should be given from time to time. Milk should not be begun and when given should be diluted. Fresh butter is preferable.

As I have said before, the treatment is very unsatisfactory and in my hands true cholera infantum has been very fatal and I hope some of you may devise a way to combat this disease that will be more successful.

In some localities the disease seems to be less severe, but from my own experience the success in the treatment lies in a mistaken diagnosis or in a very mild attack.

To recapitulate briefly—cholera infantum is rare. It is more frequent in summer months. It is more often seen in artificially fed children or those who are generally weak. It is best treated by prophylaxis. The attack itself is very unsatisfactorily treated.

## OUR PROFESSIONAL STANDING.

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By J. R. SCOTT, M. D., Independence.

I do not believe it will be necessary for me to present argument to convince you that the medical profession does not occupy the position in society to which it is entitled. That fact is evident. We deplore the passing of the family physician and the tendency of the laity to follow after strange gods. We swear softly under our breath and sometimes not so softly at the lack of intelligence on the part of individuals in choosing irregulars when seeking medical aid. We seek to pass laws that will shut out irregulars and protect the public from being a prey to the quack and faddist that abounds, with little success. The causes leading to lack of confidence in our profession lies almost, if not wholly, within ourselves. I am not here to argue the right or wrong of the question discussed in this paper, I shall present to you the topics as seen from the laymens' point of view. As they view us, we might para-phrase from St. Luke as the prayer of the present day physician. "God, I thank thee that I am not as other practitioners are, grafter, schemer, abortionist or even as this osteopath." One is almost forced to the conclusion that the prayer fits when he sees how scrupulously we keep the letter of the code and how we fail in the spirit of it.

We assume that regulars are honest and all irregulars are grafters, a conclusion that the public is not willing to accept. The laity believes there is as much honesty, culture and moral rectitude among the irregulars as the regulars, and the people look on the cry of quack and grafter, as coming from men who wish to divert attention from themselves. I believe in the principles as taught by our modern teachers, and if every practitioner followed out the teachings, both medical and ethical, all would be well, but the practice of some who conform to the letter of the code, is so rotten, that any intelligent layman knows that such are either ignorant or hypocritical. We have a code of ethics, but no ethical standards. If a man does not advertise in print and does not on his sign or card state some sectarian method he is acceptable. He may be ignorant, immoral and unworthy from every standard, yet if he conforms to the code in the two points mentioned and has a license we receive him into our counsels. Occasionally a man becomes so no-

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torious that we drop him, if the public murmur becomes too loud. The code demands that every physician be every inch a man. The profession demands that a physician shall not advertise in the newspapers. The average citizen thinks the physician a chump because he does not advertise, and concludes that he does not know much. He knows that the physician is trying to increase his business and cannot conceive of an intelligent person not using the best medium to inform the public of the things he tries to get them to believe concerning himself. The profession has not maintained an attitude above suspicion in the matter of advertising, and no one understands it better than his neighbors. They do not believe a man is half bright who will discard the press and yet strive to advertise himself in other ways, not always as creditable.

Regardless of what he may practice himself, the average citizen has a wholesome contempt for an abortionist, and there are enough of these in the regular profession to lower the profession in the esteem of the people. We all recognize and associate with men who, if circumstantial evidence be applied in such cases, are making a considerable portion of their income from such a source. Then think how easy it is to become a specialist. All that is necessary to become one is to say—go to—I will be a specialist, and straightway it comes to pass. We recognize such specialists and call them in and send them patients—well, because they are not in general practice, and therefore not in direct competition. Don't you suppose an intelligent and discriminating public is able to detect the sham, the lack of knowledge and pretense in it all. The public has a shadow on which to base the belief that we will stand by a regular regardless of merit or morals and the public be damned. Free office rent from a druggist may be alright, percentage on prescriptions merely a business arrangement, a part of the proceeds of the fee charged by a specialist or surgeon for a case referred, just compensation, and the numerous and sundry other ways in which the profits are divided, above suspicion, but the untutored and uninitiated common people call it graft and boodle.

Manola, Vin Mariani and Gray's Glycerine Tonic look exactly the same to a layman as Peruna, Swamproot and Liquozone. The difference between Unguentine Resinol or Campho Pheneque and Bucklin's Arnica Salve, De Witt's Witch Hazel Salve and Cuticura, is the difference between tweedledee and tweedledum. You may see a difference but he cannot. So when you speak of quack remedies he winks the other eye, for he thinks you are denouncing



tweedledee, while prescribing tweedledum.

The ideas advanced in this paper are not personal opinions, but the result of little quiet chats with the laity of all classes, and entered into with the idea of finding out really where we stood in the estimation of our neighbors. Nearly every family has one medical man whose word is law and gospel. I am not speaking of the individual practitioner, but the collective body of medical men: what we might term a composite view of the fraternity.

What is to follow is largely my personal views as to the remedy.

We are organized after a fashion, but we need a revival. Medical men are not awake to the significance of organization as the commercial world understands it. We want the fraternity to back us as individuals, but we do not wish to part with any individual rights in return. There is almost a total lack of mutual co-operation. We are so afraid that our neighbor in practice will get ahead, that we belittle him and magnify the ability of the man fifty or a hundred miles away. We need to get away from this, as we now interpret it and lay the stress on the essential things, learning, honesty, morality and true courtesy toward our neighbors. We need to wake up to the value of public opinion. We need the sympathy of the public, not its suspicions. We will never get on the right side of the public as long as the newspapers are hostile. What, asks one, shall we commercialize our profession by using printer's ink to urge our claims and announce our victories. Well, the schools where we are taught medicine, go out into the highways and byways and almost compel the student to matriculate. At certain seasons you all get cards, asking you to send in the names of prospective students. The opening and closing of the terms are given out in the public prints, and when times get a little dull, the faculty organize a body snatching affair or class sentiment is invoked to keep the public alive to the fact that the college is there and alive. The attitude of the teacher, since Hippocrates time, is changed. Instead of teaching your son and the sons of your teachers and not others; it is teach all you can attract by whatever means you deem most effective. Medical colleges are now run on business principles. I do not mean they neglect the scientific side of medicine, but an institution that would do no more to secure students than some would have us believe the code teaches us about getting a practice, would soon have to close up for lack of students to teach. If it is right for medical faculties to advertise for students and send out catalogues telling how well they are equipped,

wherein lies the wrong of the student, after graduating, advertising for patients and sending out circulars or booklets telling how well he is equipped. It is much more necessary for the medical man and his family to live, than for the medical school to be perpetuated. If it is wrong for the doctor to commercialize his profession, it is wrong for the school to be commercialized.

If we will quit trying to protect the public from quacks by due process of law, and pass a few laws to protect ourselves from ourselves, we will be able to convince the people we are sincere. A specialist should be obliged to show proficiency in his chosen field at least equal to the best general practitioners, before assuming his title. The man who is not interested enough in the progress of the profession to keep in touch with the advances made by buying books and journals, attending medical meetings and post-graduate schools, ought to be dropped from the list of practitioners. Such men are dead weights. They ought to be made to work or quit.

If a man is going to let a druggist pay his rent, or receive percentage on his prescriptions from the druggist, he ought to avoid the appearance of evil, post that fact in his waiting room that all may understand. If he receives part of the fee for a case referred by him to a specialist, the patient should be informed that such is the case. Should he be left in ignorance of this fact, and later find it out, he would consider that he had been held up.

We should insist on more attention being paid to the teaching of the therapeutics. We should also buy a new work on *materia medica* once in a while and study it. It is not wise to get all our knowledge from the advertisements sent out by pharmaceutical houses. They usually neglect to give the untoward action of their mixtures and compounds. Occasionally they make mistakes both as to composition and effects, and too often use the physician to popularize their compound, then go direct to the public with it. The warning to prescribe in original packages, is not used so much because of the fear of substitution as to familiarize the laity with the package. We should not encourage the houses to get out specialties and when a meritorious article is used, we should insist that it be given a dignified name, and not a catchy meaningless one. Nearly every house will tell you that specialties are money makers. The charge for them is too high for the quality of the drug exhibited, or the quality inferior.

The doctor should be the master, the chemist and pharmacist, the servant to furnish what is best for the patient. Too often, much too often, the chemist and druggist dictates what the doctor shall give.

## REPORT OF A CASE.

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By R. E. M'VEY, M. D., Topeka.

Mrs. B. M. Called January 5, 1905. Found patient suffering from pemphigus pruriginosis, or a form of pemphigus vulgaris.

Patient was covered over with large bullae, especially on abdomen and extremities. The eruptions first appeared as wheals which were very itchy and readily transformed into bullae, which were elevated above the skin, full and tense. Usually pemphigus vulgaris makes its appearance upon healthy skin, without an erythematic base and with little itching.

There is a close relationship between pemphigus vulgaris and pemphigus pruriginosis, but in pemphigus pruriginosis there seems to be a relationship between some forms of urticaria and pemphigus. Just what the relationship is science has not fully determined. Both pemphigus and urticarial elements seem to be located in the vaso-motor centers, either peripheral or central. Our study of neurons is not perfected. Anatomy shows the grosser lesions in dead tissue, but our studies now must be directed to the physiology of the functions of living tissue.

A slight embarrassment of a vaso-motor neuron, which could not be distinguished by the strongest microscope, nor by any chemical analysis, may vary the control of the blood vessels under the vaso-motor neurons. If a vein loses tone it becomes irritable and subject to spasm, and damming back of the lymph, and a wheal is the result, as the veins carry a large part of the lymph into the general circulation. The wheal formation causes pressure in the sensory filaments, thus producing the pruritis.

From the large amount of eruption on this patient, the pruritis was so intense that at night the patient had delirium. Being unable to receive proper care at her home, she was sent to Christ's Hospital on January 28.

For the intense itching we gave antipyrine, 5 grains in simple syrup, every half hour until relief and sleep were obtained or until 20 grains were taken.

Antipyrine was given for its well known properties of controlling pruriginous conditions of the skin. Administered in this way it gives relief and sleep.

As a permanent tonic arsenous acid 1-20 of a grain, quinine 3 grains was given three times a day. Arsenic is a nerve tonic in



small doses, and improves the appetite. As the itching was worse at night there seemed to be some periodicity about it, therefore the quinine was indicated.

The patient was given only fluid diet for the first four days after entering the hospital. For the rest of the time she was given semi-solid food.

Temperature ranged from  $98\frac{1}{2}$  to  $102.5-10$  Pulse varied from normal to 118 per minute.

Locally, Bismuth sub-nitrate 3 ounces and Menthol 30 grains was dusted over the bullae after cleansing with sweet almond oil.

Later, nosophen 2 drams, bismuth  $\frac{1}{2}$  ounce, magnesia carb 1 dram, was dusted on the bullae three times daily, after having cleansed the parts with sweet almond oil.

A bath was given daily, either tub or sponge.

Patient was discharged from hospital February 28, 1905, so relieved that hospital treatment was unnecessary, but treatment was continued at her home for six months, as there was a disposition for the wheals and bullae to return in a slight form. Where the old bullae had healed there was a loss of pigment. The spots were white, circular and smooth, which led me to think there was a tertiary factor lying behind the pemphigus, for which I gave potass iodide 10 grains, in elixir of pepsin, three times a day after meals, for six months, after which there was nothing left but the vitiligo spots.

Leboir has reported degeneration of the underlying nerve fibers in pemphigus and in association with vitiligo and paren-hymatous neuritis, where the axis cylinder disappears, the myelin sheath breaks down and the nerve fibers become transformed into empty primitive sheaths.

The grosser lesions that have heretofore been found by Leboir and other pathologists, accompanied by marked degeneration of the underlying nerve fibers among the sensory nerves, does not apply to all cases of pemphigus, because some of them make good recoveries within a few months, as shown in this case.

The blood changes in pemphigus:

It is said that the eosinophils cells, which are leucocytes, are increased in number and are found both in the blood and in the bullea, but as I did not know their significance or their diagnostic value, there were no blood tests made for their presence.

The microscopical findings of pemphigus:

Demme, Bullock and Pernet, have found diplococci in the



bulae. The diplococci are one-half to two-thirds larger than the gonococci. I must say that the microscopic findings of bullous affections are not very satisfactory.

Our treatment is mostly empirical and must be, until we have a more definite idea of the factors setting up the irritation.

My words poorly express the relations of the various factors making the main disease for which I treated this patient, but the results of the treatment have been good.

The governing idea as set forth in the report, is that pemphigus and other bullous affections are more physio-pathological than strictly pathological, as heretofore set forth by pathologists. Children often have pemphigus in a slight form, from which they recover under proper treatment. That this case was not strictly bullous syphilid, is evidenced by the pruritis, as syphilids do not itch.

## PARASITIC DISEASES OF THE SKIN AND THEIR TREATMENT.

By J. REED LYTLE, M. D., Richmond, Kansas.

One of my instructors in college admonished us to be diligent and careful in the study of affections of the skin; for, said he, these constitute one-sixth of all the cases for which the physician in general practice is consulted. I think this high proportion has not been maintained in my practice, and yet this class of cases is sufficiently numerous, to the patient sufficiently annoying, and to the practitioner sufficiently difficult to diagnose and baffling in treatment, to merit our careful and painstaking study.

Parasites are organisms which live within or upon the surface of the body of some other living thing upon which they feed. They may belong to either the vegetable or animal kingdom, hence may be classified as phytoparasites and zooparasites. Also, parasites inhabiting the interior of the body are called endoparasites while those forms which are parasitic upon the exterior of their host, and with which we have to do in the study of diseases of the skin, are denominated ectoparasites. Parasites are also permanent as the tape-worm or the itch mite; or they are temporary as the flea, bed-bug or mosquito.

The large group of micro-organism termed bacteria are included in the general division of phytoparasites, as are also a few forms of fungi which are of etiological importance chiefly in dermal affections.

I shall not in this paper attempt so much as to name all the diseases of the skin which are of parasitic origin but shall only speak, and that perhaps in a very desultory and informal way, of a few of these affections which are more especially interesting to me and which I hope may not be uninteresting to you.

Theoretically this class of diseases ought not to be troublesome to the physician and practically this is perhaps largely true; because the disease being the result of the presence of a parasite, and this cause being perfectly well recognized, the treatment of the disease rests upon rational grounds and consists in the application of such a remedy as will destroy or remove the parasite. This being accomplished the diseased part is speedily restored to its normal condition. But great difficulties sometimes lie in diagnosis.

Read at the Franklin County Medical Society at Ottawa, Kas., July 2, '07.

In this field, the man with the microscope and able to use it well has certainly great advantage.

We may first speak of that class of skin affections caused by the phytoparasites or vegetable parasites; and important among these are the several varieties of ringworm all caused by the same fungus called the trichophyton or ringworm fungus. All these forms of skin affections are contagious as the fungus is liable to be conveyed from one person to another and when thus transplanted to a suitable soil it again grows and develops.

Tinea Tonsurans or ringworm of the scalp is a disease of childhood; found almost exclusively before the age of fifteen years. In its treatment it is best to begin by cutting the hair short in all the affected area and having the head washed thoroughly every day with hot water and soap or a saturated solution of boracic acid or a lotion of phenol, one drachm to the pint. The washing is followed immediately by the application of the parasiticide in the form of either a lotion or an ointment. We may use mercury bichloride 2 or 3 grains to the ounce of water or alcohol; or sodium hyposulphite one drachm to the ounce. Sometimes ointments give better results than lotions and we may then use tar, sulphur, mercury bichloride, etc., or we may apply an ointment of cheysarobin 10 to 20 gr. to the ounce.

An effective form of treatment is to first soften the epidermis and hair by the application of liquor potassae and then follow by the parasiticide. We are also advised in obstinate cases to extract the hairs from the diseased area in order to gain more complete access of our parasiticides and contact with the disease fungus, but this is rarely necessary. In all the forms of tinea we should also bear in mind, in addition to the parasiticides already mentioned, that pastes, ointments and lotions of resorcin, salicylic acid, ichthyol, sulphur, chrysophanic acid etc., are all efficacious and to be resorted to with discretion.

The trichophyton fungus affecting the smooth or non-hairy portions of the body is known as tinea circinata or tinea corporis. Unlike the preceding variety it is not confined to the age of childhood. It most generally affects the exposed surfaces of the body, viz., the face, neck or hands. It is usually readily recognized by its presenting first a patch of small, scaling papules. This patch extends peripherally while healing occurs in the center; so that we soon have the characteristic ring enclosing a center of normal integument. When the disease occurs in numerous patches involv-

ing the general surface of the body, or when the ring-ilke appearance is lacking, we may experience difficulties in diagnosis. These cases yield readily to treatment and a cure is speedily secured by application of the milder parasitocides. One-third phenol and two-thirds olive oil is so nearly a specific that I scarcely ever think of anything else. Almost anybody will volunteer to give the doctor pointers in the treatment of ringworm. They frequently do not apply to the doctor for treatment but he may be called upon to relieve them from the undesired results of their own remedies. I recently had the case of a young man who had some sort of eruption, probably ringworm, on his upper lip, to which, upon his own volition, he had applied a solution of copperas. He soon had a severe dermatitis with much swelling and oedema of the lip, for the relief of which he sought the doctor.

Tinea Sycosis or ringworm of the bearded portion of the face is usually called barbers itch and is usually contracted in barber-shops. It is a formidable disease and will often tax the utmost resources of the physician. It is much more inflammatory than the other forms of ringworm, the trichophyton fungus penetrating deeply into the hair follicles and there exciting severe inflammation. At first papules then postules are formed and the exudite results in more or less crusting. The crusts must be removed by soaking with olive oil and washing with some of the germicidal soaps and hot water. All the diseased hairs must be extracted which operation is painless, as the hairs lie loose in their follicles. If the face is much swollen and painful the mild parasiticide applications must first be made. When the inflammation has subsided the lotions and ointments are to be increased to full strength.

Tinea Favosa or favus is caused by a variety of the trichophyton fungus affecting the skin and its appendages, the hair and nails. It is most common on the scalp but may affect the general surface. The disease is rarely contracted by adults and tends to great chronicity. It usually is found among the children of the poor classes of our foreign population. It attacks some of the lower animals as rabbits, mice, birds and cats and is frequently conveyed to children from these. In fully developed cases there is a peculiar mousy odor which is diagnostic. The treatment is purely local and embraces the usual parasitocides, but requires as adjuvants great patience and perseverance.

Tinea Versicolor is a disease coming in this class of phytoparasitic skin diseases. I only mention it to say it cannot be very



common in this country as I have never seen it but once or twice. It is usually but a trivial affection and perhaps people do not consult a physician for it.

Blastomycetic Dermatitis is a disease caused by infection from the yeast fungus. It is only in comparatively recent years that the affection has been recognized. At a meeting of the American Dermatological Society in May, 1894, Dr. T. Casper Gilchrist of Johns Hopkins University, exhibited microscopical skin sections illustrating an hitherto undescribed disease. In pus obtained from the same patient Dr. Gilchrist discovered numerous microscopic bodies which were later identified as blastomycetes or yeast fungi; and, as a result of his investigations, it was Dr. Gilchrist who first used the term blastomycetic dermatitis as applied to this newly discovered condition. The disease is quite a rare one. Up to six years ago only nineteen cases had been reported in medical literature. I had the good fortune recently to see a case of this disease which I shall briefly report. The patient, Mr. H., living a few miles out from Richmond, is a farmer whose general health is excellent. Family and personal history unimportant as not bearing on the present condition. Last November Mr. H. first noticed a sore, to which he paid little attention, on the inner side of left arm, midway between elbow and axilla. It was superficial and discharged some pus and extended over a surface which might be covered by one's thumb. After perhaps two months it healed spontaneously, leaving as a scar a patch of atrophied skin of a decidedly blue color. Probably before this had altogether healed a patch developed on dorsal surface of left wrist and later on over the first phalanx of the ring finger of same hand. These lesions were of irregular shape, the one on the back of the wrist being about two inches long. I was first consulted by the patient March 17. These patches presented a decidedly inflammatory condition of the skin with the thickening of the epidermis and a nodular or tubercular appearance. Scattered through the integument of the affected area were many minute abscesses which from time to time would rupture upon the surface, each discharging a minute globule of pus. Sometimes a few of these abscesses close together would unite to form a small ulcer, discharging pus for a few days, then heal and others appear in some other portion of the affected surface. Dr. Herr saw this case with me. A dermatitis from some form of infection was as close as we could get to a diagnosis. The case improved under our treatment but did not

get well and about the beginning of last month I referred the patient to Dr. Lyle of Kansas City, who diagnosed blastomycetic dermatitis. As Dr. Lyle is with us this evening I am sure we will all be glad to hear from him a fuller discussion of this affection than I am able to give you.

The bacillus tuberculosis or bacillus of Koch is a strict parasite. It is the producing cause of several affections of the skin among which we may name lupus vulgaris, tuberculosis verucosa eritis and scrofuladerma. A localized skin tuberculosis is sometimes produced by accidental inoculation at autopsies.

Lupus treated by intravenous injection of etherial sol. of iodoform. Cure in 40 days, 14 years standing. British Medical Journal quoted in June Clinical Med. Erysipelas is a disease caused by the invasion of a bacillus of the streptococcus variety first observed by Koch. It has its seat upon an epithelial surface either of the skin or of a mucous membrane, and may also invade deeper tissues.

Leprosy is a disease produced by the bacillus leprae. It may affect all the tissues of the body but some forms affect more especially the skin which becomes thickened and pachydermic and is also the seat of new growths in the form of nodules producing the type of disease called lepra tuberosa. Leprosy may only be mentioned as a curiosity, being comparatively rare in this country. In 1902, there were in the United States, a total of 278 cases, the states credited with the highest number of cases being California and Florida, with 24 cases each. While a student in Rush College I had the good fortune to see a case of leprosy in the dermatological clinic of Prof. Hyde. The patient was a middle aged man, a farmer, from Nebraska. He was a Norwegian and probably brought the infection with him from his native country as we are told there are many cases among the Norwegian peasants. This case was of the tubercular form of the disease and I remember Prof. Hyde's prescription was for the internal and external use of chaulmoogra oil. What the outcome of the case was I never learned. Recent writers claim benefit in some cases from the X-ray treatment. They claim it cures by killing the bacillus.

Coming now to the second class of parasitic skin diseases—those caused by the zooparasites—scabeis or itch, easily holds the place of preeminence. It is caused by an animal parasite, the acarus scabiei or itch mite. The character and habits of this troublesome animal have been very accurately observed and described. We are told it is the female only which attacks the skin, the male merely

remaining upon the surface. The female acarus burrows under the epithelium for the purpose of laying her eggs. She lives about two months and lays in this time about 50 eggs which hatch in two weeks. The most characteristic lesion found in scabies is the burrow or cuniculus of the female acarus which she makes as she tunnels under the epithelium. The presence of the itcn-mite excites various grades of inflammation so that we find papules, vesicles and pustules intermingled; and in addition to these the various traumatisms resulting from the use of the finger nails in scratching. The disease is markedly contagious and yet does not seem to be conveyed by ordinary contact but only by prolonged exposure, such as wearing infected garments or sleeping in infected beds. There are several facts which must be considered in connection with the question of contagion. In the first place the acarus family find nutriment, shelter and all they require for comfort on the person of the individual whose skin they inhabit; and there is no great inducement for them to colonize upon a strange skin at the instant of the first opportunity offered. In the second place, the transfer of a male acarus alone, from one person to another would not insure a generation of the young. In the third place the unimpregnated female could not alone accomplish a large success as regards progeny; and lastly the eggs alone would not suffice, for these have to be nicely planted within the epidermis, in order to be hatched safely to maturity. In brief, only the more intimate contacts of the bed at night, and the application of nails charged with acari of both sexes, especially the young, are to be regarded as most effective for the transmission of the disease. Almost invariably the site of selection for the attack of the disease is the hands; after these the flexor surfaces of the wrists, elbows, axilla, abdomen, buttocks, the penis in the male and the breasts in the female being especially invaded. The cuniculi are usually most typically seen in the interdigital spaces and up on the sides of the fingers. Following the penetration of the parasite a rose-colored papule appears and upon its apex a small transparent vesicle becomes developed, accompanied by intense itching. When these vesicles remain uninjured their contents in a few days will become opaque and purulent, thus forming pustules which burst spontaneously, and these leave behind them a yellow circular crust. But if the vesicles are prematurely scratched open, as is usually the case, these irritated spots bleed a little and a small black crust is formed. By the coalescence of single pustules, ulcers of consid-



erable size sometimes result. In all cases we see to a greater or less degree the results more directly following the act of scratching; as abrasions, excoriations and a more or less severe dermatitis.

The treatment of scabies has for its aim the destruction of the acari and their ova and the relief of the dermatitis. The parasiticide may be an ointment or a lotion and the choice of the particular remedy must be determined, among other things, by the age of the patient and the extent of the inflammation. The milder remedies must be used in the case of small children and in adults with delicate skin. Also if the skin is greatly inflamed irritant applications must be avoided as much as possible. Sulphur ointment is the classical remedy for scabies. It kills the itch-mite; and we may ask, "Why seek farther for a remedy?" What more is required? Life is too short to be taken up in the quest after non-essentials; but some may not wish to be confined to this one remedy which is so trite with the laity. We may then use Balsam of Peru which is a sovereign remedy and has the advantage of being entirely non-irritating and is therefore especially applicable to those cases in which the skin is much inflamed. A unique method of applying sulphur may be used also by way of variety, viz., by fumigation. The undressed patient is placed upon a cane-seated chair and a blanket placed around him, covering him from the neck to the floor. A tripod supporting a tin plate is placed under the chair; an ounce of sulphur is placed in the plate, and a spirit-lamp is lighted under the plate. At the end of twenty or thirty minutes the patient is usually cured. In no case, we are told, do we need to use more than three fumigations.

Any discussion of scabies, especially the matter of its diagnosis, of course brings to the front the question of its identity or non-identity with the so-called "prairie itch," "Texas mange," "prairie digs," etc., of which we are accustomed to see many cases every winter.

The question of whether or not this is a parasitic affection and whether it is not really scabies has been much debated. Much has been said on both sides and after all arguments have been advanced each debater remains probably "of the same opinion still." But numerous as the cases of this troublesome itch are and wide-spread as they are, being constantly brought to the attention and under the observation of competent medical men, it seems that a satisfactory conclusion as to the nature of the disease ought to be arrived at and be accepted by the profession in general. I believe the opinion



of our best observers and of the most scientific men of the profession is that the so-called "prairie itch" is a disease entirely distinct from scabies; that it is induced by atmospheric conditions, viz., by variations of the atmospheric temperature, especially in cold weather that it is therefore non-parasitic and non-contagious. It usually goes by the title "*pruritis hiemalis*." The northeastern part of the United States seems to be the portion where the most numerous cases occur.

In a paper published a few years ago, Prof. James Nevins Hyde enumerates some of the facts which go to prove that this affection is not scabies. He observes that scabies and these winter affections are surprisingly alike but the reason for this resemblance is clear. In all, the skin is greatly irritated; in the one case by cold air—in the other by the attacking parasite. The result is the same—a pruritis in degree in different cases, but which may be as severe in one disease as in the other. Then follows the scratching which gives almost the same clinical portrait to each of the affections named. But epidemics of scabies do not affect the great mass of the people of a community as these winter affections frequently do. Everything said and done, scabies is one of the filth diseases, while these winter disorders of the skin affect all classes alike; those who wash as much as those who do not wash; the occupants of the mansions of the wealthy as well as the cottages of the poor. The general involvement of all or of a very large number of people at one time in a given community points always to a disease cause of very wide operation; and such a cause, in these winter affections, can be recognized in temperature changes in the atmosphere. These winter disorders are better and worse according to temperature changes and are not benefitted, to any appreciable extent, by the external use of parasiticides. They are benefitted by the treatments usually employed for pruritis and eczema; and if left wholly untreated they usually cease of themselves in the course of at most a few months. On the other hand the course of scabies is ever toward a steady aggravation unless arrested by proper treatment.

Two years ago, Dr. John Mayer of Osmond, Nebraska, wrote in the Alkaloidal Clinic, offering to the profession an infallible remedy for prairie itch. To those who wrote to him he sent prescription for his remedy with directions how to use the same. Inasmuch as his prescription is an ointment containing sulphur and balsam of Peru and as he recommends boiling or baking all cloth-

ing and bed-clothes, it is evident he regards it a parasitic disease. Then he proceeds to disappoint our high hopes by saying the treatment cured most of his cases. Most of them would probably have gotten well had they been left altogether untreated.

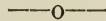
Of the temporary parasites of the skin we have annoying examples in the pediculi or lice. Pediculosis capitis is to be treated by the application of parasiticide ointments or lotions as well as mechanical means. One of the most effective applications is kerosine.

For pediculosis corporis or body lice the clothing must be frequently changed. Lotions of thymol or phenol may be prescribed.

Pediculosis pubis or crab-lice may be readily cured by applying mercurial ointment; but much more elegantly by a lotion of mercury bichloride 1:50. Lice do not remain long with persons of cleanly habits.

We are accustomed to look upon fleas and mosquitoes as more annoying than dangerous as their bites usually cause only a temporary inconvenience. But since we have learned of recent years that mosquitoes are the carriers of the malarial and yellow fever germs, they have assumed a very important role; and it is easily conceivable that fleas also may become and often are the carriers of the germs of infectious and septic matter.

I shall close my paper with an inquiry for information. What is the insect which people generally call the chigger? Dr. Scott of New York, describes the chigger as a very formidable insect. He says it is indigenous to South America and is confined to the tropics and sub-tropics. The impregnated female bores into the skin where she deposits her eggs. If the insect be allowed to remain in the tissues a severe inflammation ensues which only ceases on the extraction of the chigger. If the part be still neglected ulceration occurs and, if several chiggers be present in close proximity, the union of several ulcers may give a very ugly sore. Is ours the chigger, or is it the septus irritans or red bug?



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# THE JOURNAL OF THE KANSAS MEDICAL SOCIETY.

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CHAS. S. HUFFMAN, . . . . . EDITOR

J. E. SAWTELL, }  
GEO. H. HOXIE, } ASSOCIATE EDITORS

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**Meeting of State Society.** The Kansas Medical Society will meet at Iola May 6, 7 and 8, 1908.

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Dues for the year 1908 should be paid at once, so that all members may receive their 1908 membership card.

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The association of State Secretaries and Editors will meet in Chicago June 1, 1908. This will be the second annual meeting, it being formed only one year ago. The Atlantic meeting was of the greatest value to those who were present, by comparison of methods used in different states in an association. This matter of having a representative should be taken up by the House of Delegates and discussed at the Iola meeting.

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**The "Specialist."** When we see two surgeons qualifying as experts on insanity, as occurred in a recent murder trial in Kansas City, we are startled into wondering whether surgery is a specialty or a part of the work of every general practitioner. To the disinterested observer it seems as if the surgeon has no right to ask general practitioners to refer patients to him unless he is willing to become a real specialist, instead of a "tin-horn" one. Such "expert" testimony does more to damage the fair name of medicine—to injure you and me, my brother—than all the osteopathy or Christian Science let loose from the asylum. Hence we shall do well to encourage real specialism and support the real specialists.

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**The "Internist."** A physician in Kansas City recently stated that the prevailing opinion in that city seems to be that an internist is

one who doesn't know enough to be a surgeon. This is rather discouraging to those young men who in the laboratory and clinic are doing more to advance the science of medicine than the surgeons can hope to do even with their utmost dexterity. The falsity and evil consequences of the belief are of course evident upon very slight consideration, but unless the rank and file of the profession honor those who really are specializing in internal medicine and take to them their obscure cases for diagnosis, this opinion will become the actual condition and internal medicine will be dead in the Middle West.

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After the April issue of the Journal the place of publication will be changed from Columbus to Kansas City, and Dr. James W. May will have charge as editor. The present editor found it impossible for him to continue in charge of the Journal, owing to other demands on his time, and so notified the council. At a meeting of the council held in Kansas City March 18, 1908 Dr. May was elected editor and will assume control of the Journal May 1.

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### **Annual State Meeting.**

Preliminary announcement of program of the meeting of the Kansas Medical Society at Iola, May 6, 7 and 8, 1908.

Meeting of Council, Tuesday, May 5, at 4 p. m.

Meeting of the House of Delegates Tuesday, May 5, at 8 p. m.

The general sessions will open Wednesday May 6 at 9 a. m. Address of welcome by the mayor and response by Dr. C. C. Goddard of Leavenworth.

Annual banquet, Thursday May 7, at 7 p. m., at New Portland Hotel.

Meeting of the House of Delegates Friday, May 8, at 9 a. m. for election of officers.

A trolley ride will be given by the business men of Iola to visiting physicians, to the different places of interest, the date of which will be announced at the meeting.

The regular program will be mailed to all members at an early date.

All visiting physicians' wives are invited to attend, and the ladies of Iola have made special arrangements for their entertainment.



THE JOURNAL OF THE  
SCIENTIFIC PROGRAM.

1. "Infection of the Hand and Fingers," L. D. Johnson, Chanute, Kan.

(Abstract) Anatomy,—Method of extension of the infection, Location of the extension, Treatment, etc.

2. "Sociological Aspect of Gonorrhoea," S. C. Emley, Lawrence, Kan.

3. "Bacteriology and Pathology of Acute Rheumatism," C. C. Westlerode, Kansas City, Kan.

4. "The Treatment of Colitis," H. L. Snyder, Winfield, Kan.

5. "Indications Calling For, and Some Points in the Technic of the Modern Mastoid Operation," T. R. Edwards, Chanute, Kan.

(Abstract) Imperative indications calling for early resort to operative measures—More frequent recourse to mastoid operations in a great number of cases of chronic otorrhoea—Technic of mastoid operations.

6. "Hysteria, With Report of Cases," O. S. Hubbard, Parsons, Kan.

7. "Convulsions, Result of Complete Vaginal Atresia," G. B. McClellan, Weir, Kan.

(Abstract) Subject, girl 18 years of age, strong and well developed. Treatment and result.

8. "Some Observations on the Work of the State Board of Health," J. S. Crumbine, Topeka, Kan.

(Abstract) First, the work of the Board under the general health laws; Second, under the department of food and drugs;

Third, the work of the Board under the water and sewage law; Fourth, the work of the bacteriological department.

9. "Gunshot Wound of Abdomen," W. S. Grisell, Ransom, Kan.

(Abstract) Report of a case which occurred in private country practice.

10. "Hodgkin's Disease With Report of Case," H. W. Manning, Eureka, Kan.

(Abstract) Review of literature up to date, Discussion of Etiology, Symptomology, Pathology, Treatment.

11. "Gastro-Intestinal Neurosis," W. R. Heylmun, Iola, Kan.

(Abstract) Some observations regarding our lack of knowledge as to the etiology and nerve derangements back of these disorders; Their complex symptomology; Their frequent relationship to neurasthenia and hysteria; Their frequent dependence on abnormal conditions in remote parts of the body; The difficulties often attending

their differentiation from organic diseases; With short review of the most approved methods of treatment.

12. "Roentgen Ray Diagnosis and Therapy," Edw. H. Skinner, Kansas City, Mo.

(Abstract) Exactness and detail with which the Roentgen negative records fractures and diseased conditions of the osseous system. The diagnosis of calculi in the genito-urinary tract and biliary calculi. The diagnosis of mal-positions and lesions of the alimentary tract by the bismuth Roentgen method. The present status of Roentgen Therapy in cancer, leukemia and skin lesions.

13. "The Management of Peritoneum During Labor," S. L. Brooking, Paola, Kan.

14. "Prostatic Hypertrophy," L. H. Munn, Topeka Kan.,

(Abstract) Some Anatomy; Less physiology; A little pathology; and more devoted to a plan that the treatment is surgical, and for an early operation.

15. "Local Anesthesia in Hernia." M. F. Sudler, Lawrence, Ks

16. "Opsonins and Agglutinins," L. R. Sellers, Osawatomie, Kan.

(Abstract) Bi-products of bacteria; Production of antibodies. Antitoxins and agglutinins. Widall's test. The action of phagocytes. The changes produced in bacteria by opsonins; The opsonic index, and how taken. Immunity, natural and acquired against many diseases. Serum therapy progress of, and future hope of.

17. "General Anesthesia," F. K. Day, Neodesha, Kan.

18. "The Relation of the Physician to Mental Healing, System and Methods," Rev. S. S. Hilcher, Iola, Kan.

19. "Treatment of Fracture of Leg," G. P. Marner, Marion, Kan.

(Abstract) Classification of fractures; Special reference as to position; Splints with provision for extension and counter extension.

20. "Should Kansas Maintain an Institution for the Care of Her Tubercular Citizens?" J. A. Milligan, Garnett, Kan.

(Abstract) The state should have such an institution; Why?

21. "Blastomycetic Dermatitis, With Report of Cases," F. B. Lyons, Wichita, Kan.

(Abstract) Definition; History; Etiology; Bacteriology; Pathology; Occurrence; Appearance; Locations; Symptoms; Diagnosis; Prognosis and Treatment; Report of cases.

22. "The opportunity and Duty of the Kansas Medical Society",

W. H. Graves, Wichita, Kan.

(Abstract) Some oppressive burdens that medicine is carrying and the relief to be afforded by the Kansas Medical Society.

23. "Apomorphine," J. W. Neptune, Salina, Kan.

24. "Dieto-Therapy of Acute Fevers," C. F. Menninger, Topeka, Kan.

(Abstract) First, Historical review; Second, Characteristics of fibrile disease; Third, Classification of fibrile disease; Fourth, Dieto-Therapy as a part of the treatment of fevers; (1) As supporting the therapy upon the etiological point of view; (2) As a part of the antipyresis; (3) Nutrition as a part of the stimulation; (4) Nutrition as influencing the renal functions; (5) The form of nourishment with reference to the digestive apparatus; (6) Nutrition as influencing the metabolism.

25. "The Liquid Treatment of Colitis, With report of Case," H. L. Snyder, Winfield, Kan.

26. "Tonsils," J. F. Gsell, Wichita, Kan.

(Abstract) Anatomy, Function, Indication for Removal.

27. "Palsies of Childhood," O. D. Walker, Salina, Kan.

28. "Exophthalmic Goitre," J. B. Edwards, Chanute, Kan.

(Abstract) Early diagnosis of. Frequency in this locality. Some thoughts on causes and treatment of same.

29. "Doctors and Medicine; Past and Present. Have they More Blessed than Cured Humanity?" J. Dillon, Eureka, Kan.

30. "The Influence of Physic-Chemical Theory on the Future of Medicine," G. C. Glynn, Iola, Kan.

(Abstract) Phylosophy of advancement in medical science; Effect of some of the most widely accepted theories. Latest conceptions in physics and chemistry; Slow changes and modifications likely to result therefrom.

31. "Eye symptoms of Diagnostic Value to the General Practitioner," A. H. Rogers, Altoona, Kan.

32. "Hypersensitiveness Induced by Diptheria Antitoxin and other Serums," Professor M. A. Barber, Lawrence, Kan.

33. "Vaccines," Dr. Trimble, Lawrence, Kan.

34. Paper, C. D. Blake, Ellis, Kan.

35. Paper, R. M. Bennett, Mound Valley, Kan.

36. "Calcareous Degeneration of Cystic Ovary," F. W. Shelton, Independence, Kan.

**SOCIETY NOTES.**

The meeting of the Western Kansas Medical Society was held at Colby on March 18th with a good attendance.

Dr. V. C. Eddy read a paper on Empyema and its Treatment that contained many practical suggestions and reported six cases.

Dr. F. H. Smith presented a paper on the so-called "Specific Treatment" of pneumonia, giving statistical data and showing much care and extensive collateral reading in its preparation. He does not believe in "specific treatment" and emphasized the importance of plenty of fresh air and low room temperature.

Dr. I. B. Parker gave an address on the early recognition, prophylactic and general treatment of tuberculosis, a paper that was greatly appreciated as the subject is one that presents ever varying phases. The doctor's paper showed a thorough familiarity with his subject, presented all the new methods of applying the tuberculin test, dealt with the sanatoria and outdoor treatment, and especially emphasized the necessity of medical supervision of the patient's hygiene, exercise and diet.

Dr. F. A. Carmichael read a paper on chronic myofribois, with reference to the obscurity of its pathology, indefinite symptomatology, its possible relation to the Stoes-Adams Syndrome, with remarks on its treatment.

All papers were fully and generally discussed.

Everyone felt that the meeting was a thorough success.

The following officers were elected for the ensuing year.

President, Dr. I. B. Parker, Hill City; Vice President, Dr. C. D. Blake, Ellis; Secretary, Dr. F. A. Carmichael, Goodland; Treasurer, Dr. C. M. Miller, Oakley; Member Board of Censors, W. M. Beaver, Colby; Delegates to State Meeting, Dr. V. C. Eddy, Dr. I. B. Parker.

The following resolutions were adopted, as read:

Resolved: First—That we favor a bill granting to State Boards of Health the power to regulate and control medical colleges within their respective states and to pass upon and determine the educational qualifications of applicants for admission thereto.

Second, That we endorse the action of the State Board of Health in the establishment of a state Bureau of Hygiene and favor a state appropriation of not less than \$3500.00 per annum for its maintainance. The present appropriatoin of \$500.00 per annum being entirely inadequate for its proper care and maintainance.

Third, That we heartily endorse the action of the state leg-



islature in the passage of pure food and drug laws and favor the rigid enforcement of the same.

Fourth, That we favor a bill regulating the practice of so-called "Osteopathy" in the state of Kansas, which, at the present time is without legal restriction or liability. That we condemn this so-called system of healing as a wholesale system of charlatanism, its practitioners and advocates drawn from the most ignorant and illiterate classes. That the chief claim made for, and upon which, with the characteristic easy going, careless and short sighted method so commonly witnessed in legislators in dealing with questions vital to the public health has permitted them to gain a foothold in the state i. e., That their methods do not comprehend the administration of any drug or medicine hence are harmless, has been absolutely disproven.

That these quacks and charlatans are a direct menace to public health, that their methods are irrational, unscientific and based on no recognized system of pathology and are more often provocative of evil than of good results to their deluded adherents.

That we as, regularly qualified physicians, have a right to demand for our own protection and that of the community at large, an examination in those common school branches and in the fundamental branches of medicine comprising anatomy, physiology, hygiene, chemistry and diagnosis, examination equal to that required of regularly graduated physicians.

Fifth, That we ask the cooperation and support of the organized profession of the state in securing legislation to this end.

Sixth, That a copy of these resolutions be spread upon the minutes of this meeting and a copy forwarded to the Secretary of the State Society for publication.

F. A. CARMICHAEL, M. D.  
D. R. STOVER, M. D.  
Committee.

The next meeting will be held at Colby in July.

F. A. CARMICHAEL, Secretary.

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The preliminary program of the American Practological Society is being sent out. The tenth annual meeting will be held in Chicago June 1 and 2, 1903. Headquarters and place of meeting, Palmer House.

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The Fourth annual Conference of the Council on Medical

Education of the American Medical Association will be held in the parlor, on the second floor of the Auditorium Hotel, Chicago, Monday, April 13, 1908.

### PROGRAM.

10:00 a. m., Morning Session.

1. Address of the Chairman, Dr. Arthur Dean Bevan, Chicago.
2. Report of the Secretary, Dr. N. P. Colwell, Chicago.
3. Report of Committee on Preliminary Education, Chairman, Dr. John H. Long, Professor of Chemistry, Northwestern University Medical School, Chicago. Dr. Charles R. Bardeen, Dean, College of Medicine, University of Wisconsin, Madison; Dr. Geo A. Piersol, Professor of Anatomy, University of Pennsylvania, Philadelphia; Discussion opened by Dr. Chas. S. Sheldon, representing the American Academy of Medicine, Madison, Wis.

4. Report of Committee on what should constitute a Medical College in good standing: Chairman, Dr. Victor C. Vaughan, Dean, College of Medicine and Surgery, University of Michigan, Ann Arbor. Dr. Wm. J. Means, Chairman, Judicial Council, Association of American Medical Colleges, Columbus, O. Dr. Geo. W. Webster, President of the State Board of Health of Illinois, Chicago. Discussion opened by Dr James W Holland, Dean, Jefferson Medical College, Philadelphia

2<sup>1</sup>/<sub>2</sub> p m, Afternoon Session

- 5 Report of Committee on the Essentials of a Model Medical Practice Act. Chairman, Dr. Beverly D. Harrison, Secretary of the Michigan State Board of Registration in Medicine, Detroit. Dr. F. Dudley Tait, Chairman, Credential Committee, Board of Medical Examiners of California, San Francisco. Dr. Wm. Warren Potter, President of the State Board of Medicine Examiners of New York. Discussion opened by Dr Alexander R Craig, Secretary of the Committee on Public Policy and Legislation of the Medical Society of the State of Pennsylvania, Philadelphia Discussion, The Character of the State Medical Licensing Examination, Dr. J. W. Bennett, Secretary of the State Board of Medical Examiners of New Jersey, Long Branch; Dr. W. T. Councilman, Professor of Pathology, Harvard University Medical School, Boston; Dr. F. F. Westbrook, Dean, College of Medicine and Surgery, University of Minnesota, Minneapolis; Discussion, Practical Ideas Concerning Reciprocity, Dr. A. Ravogli, President of the State Board of Medical Examiners of Ohio., Cincinnati; Dr. S. D. VanMeter, Secretary of the State Board of Medical Examiners of Colorado, Denver.

**Sumner County Medical Society**

Meet with the Sumner County Medical Society Thursday evening, March 26th, at the Commercial Club Rooms, Wellington, and help with this Program:

1. Hyperchlorhydria, Dr. Gerald Shelly.
2. 1908 Smallpox, Dr. Emerson.
3. Errors of Refraction, Dr. R. H. Shippey.
4. Gynaecology: (a) Electro therapeutics, Dr. Holt; (b) Gonorrhoea Complications, Dr. J. J. Sippy; (c) Common Ills Following Confinment, Dr. Coplan.

Plans for programs for future meeting in 1908 will be presented.

The 1908 dues must be sent to the state society this month. If you have neglected this, send me your check for \$3 at once.

Come and make this a grand, good meeting—Thursday evening, March 26th.

T. H JAMIESON, Secretary.

J. J. SIPPY, President.

ALTON H. REA, Vice President.

**Clay Center Hospital.**

The stockholders of the Clay Center hospital held their annual meeting Thursday evening, the principal business being the election of trustees and they in turn elected the officers for the coming year.

The trustees are: M. G. Patterson, X. Olsen, C. C. Stillman, B. F. Morgan and M. C. Porter. The officers elected are: President, M. G. Patterson; Vice President, B. F. Morgan; Secretary-Treasurer, Will Docking.

The resignation of Mrs. Bohring as superintendent was received, but not accepted. It was taken under consideration until a later meeting.

**Decatur and Norton County.**

Program for Decatur and Norton County Medical Society at S. C. Standard's office Clayton, Kansas Wednesday, April 8, 1908 at 2 p. m.

Paper C. W. Cole.

"Anatomy and general evidence of Intestinal Diseases" C. G. Brethhouwer.

Clinic, S. C. Standard.

Your presence requested.

C. G. BRETHOUWER, President.

C. S. KENNEY, Secretary.

**BOOK REVIEW.**

**Practice of Medicine for Nurses.** A Text book for nurses and students of domestic science, and a hand-book for all those who care for the sick by George Howard Hoxie, M. D., Professor of Internal Medicine, University of Kansas, with a chapter on the Technic of Nursing, by Pearl L. Laptad. Just ready. 12 mo of 284 pages illustrated, Cloth, \$1.50 net. W. B. Saunders Company, 925 Walnut Street, Philadelphia.

This little volume supplies a long felt want, by those who spend their lives caring for the sick. It is especially a text book for nurses, but every physician should have a copy, for in so many instances the physician has to depend upon nurses who are not trained, and this book is a valuable aid in imparting knowledge of the art of caring for the sick, and giving instruction to untrained nurses. Dr. Hoxie is to be congratulated on his work, and efforts in the production of this book.

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**The Blues.** Splauchnic Neurasthesia, Causes and Cure, by Albert Abrams, A. M, M D, F. R. M. S., San Francisco. Third edition. Cloth 12mo pp. 287, Illustrated, New York, E. B. Treat & Co. 1908. Price \$1.50.

There is no doubt that much of neurasthenia is due to postal congestion and euteroptosis. As we said in our review of the first edition, Dr. Abrams is a stimulating writer, therefore this book has proven helpful to many, and will repay any who ponders its suggestions. G. H. H.

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**Surgery; Its Principles and Practice.** In five volumes, by 66 eminent surgeons, edited by W. W. Keen, M. D., L. L. D., Hon. F. R. C. S., Eng and Edin., Emeritus Professor of the principles of surgery and the practice of surgery, Jefferson Medical College, Philadelphia. Volume III has 1132 pages and 562 text illustrations and 10 colored plates. Published by W. B. Saunders Co. 1908. Cloth \$7 per volume.

This volume of this set differs from the two preceding in that it deals with surgical material exclusively and from an operative standpoint. For that reason it is of greater value to the operative surgeon while the first two volumes are of value to the surgeon and internist equally.

The surgery of the Head is by Harvey Cushing of Johns Hopkins, Surgery of the Neck by E. W. Andrews of Northwestern;



Diseases of the Thyroid by Kocher of Berne; The Nose and its Accessory Sinuses by Harmon Smith, of the Eye, Ear and Throat Hospital of New York. Brewer of Columbia contributes two chapters, one on the Surgery of the Larynx and Trachea, and the other on the Thorax. Finney of Johns Hopkins, writes on the Surgery of the Breast, Edmund Oen of the Royal College of Surgery contributes the chapter on the Mouth, Teeth and Jaws, and J. C. DaCosta writes the chapter on the Surgery of the Tongue. J. C. Munro of the Carney hospital, Boston, writes a chapter each on the technic of Abdominal Surgery, the Surgery of the Abdominal Wall and the Surgery of the Peritoneum and the Retroperitoneal space. George Gottstein, Surgeon in Chief of the Jewish hospital, Breslau, Germany, devotes 45 pages to the Surgery of the Esophagus. Mayo Robeson writes the chapter on the Surgery of the Stomach, The Mayo Brothers of Rochester, Minn., write the chapter on the Surgery of the Liver, Gall and Bladder, and the Biliary Ducts and Moynihan of England writes a chapter each on the Surgery of the Spleen and the Pancreas.

Certainly an array of surgical talent seldom found contributing to one volume, and each contributor apparently selected according to his peculiar fitness for the particular subject. The extensiveness and thoroughness of the volume may be judged from the fact that one may find considered everything from chapped lips in the chapter by Owen, to a resection of the liver in the chapter by the Mayos. Not the least valuable for the scientific surgeon is the extensive bibliography after each subject, aiding one very materially in writing up a subject.

Any surgeon interested in the head and trunk will find in this volume all the best and latest information set down in a systematic and comprehensive way. The index is complete, making it easy to find any particular thing, and the writer has not yet failed to find whatever he looked for, regardless of its rarity or infrequency. S. C. E.

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**Braycardia and Thachycardia**, with complete English abstracts and foreign bibliography. Part II, in a series of monographs on the Symptomatology and Diagnosis of Respiration and Circulation, by Prof. Edmund VonNeuser, Professor of the Second Medical Clinic, Vienna; Associate Editor of Nothnagl's Practice of Medicine. Authorized English Translation by Andrew MacFarlan, Professor of Medical Jurisprudence and Physical Diagnosis, Albany Medical

College, etc. 150 pages. Cloth Price \$1.25 prepaid. New York, E. B. Treat & Co. 1908.

Your reviewer has always felt a need for an exhaustive study of the symptoms of disease, for none of the ordinary texts or diagnosis presents the matter in that way. On the contrary these texts constantly present us symptom complexes. The Homeopaths really studied disease from the standpoint of the symptom. Every diagnostician must analyze his symptoms if he would arrive at a logical conclusion.

Hence the JOURNAL welcomes the translation of Von Neuser's work and wishes for it success.

In this volume all the causes of bradycardia and tachycardia are mentioned and classified, and while the method is teutonic, yet the work will prove very helpful to every general practitioner. G. H. H.

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**Woman:** A treatise on the normal and pathological emotions of fine love, by Bernard Talmey, M. D., New York City. Second edition. Cloth, 8vo, pages, 58, 23 illustrations. Price \$3. Practitioners Publishing Co., New York.

That our judgment of the value of this book was correct is proven by the appearance of the second edition within four years. It is the only book that gives succinctly and dispassionately a study of woman and the characteristics of her sex; therefore we that it may find continued success. G. H. H.

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**ABSTRACTS.**

**Puberal Anemia.** Broad clinical experience certainly tends to support the opinion of many medical men that chlorosis is practically limited to the female sex, and to these during the child-bearing period. As is well known chlorosis is hardly a true anemia, inasmuch as it consists rather of a decrease of hemoglobin than an actual marked or constant diminution in either the corpuscles or mass of the blood. There is a true anemia, however, which occurs at or about puberty and is common to both sexes. This may properly be spoken of as a puberal anemia and manifests itself by both oligocythemia and oligemia. Young men, as well as young women, are attacked and the cause seems to rest on actual structural deficiencies rather than on emotional influences, as is generally believed to be the case in chlorosis. It is slow and insidious in its onset and is characterized by a pallid bloodless appearance quite different from the greenish color of chlorosis. Examination of the blood shows a greater or less decrease of hemoglobin, but unlike chlorosis, the red cells and total quantity of the blood are lowered very markedly. Strange to say, however, the specific gravity is usually raised in puberal anemia, while in chlorosis it is generally lowered.

One pronounced clinical symptom referable to the pulse, according to a prominent English authority, will moreover be found in puberal anemia, which is not common in chlorosis. In anemias of failing quantity, such as puberal anemia, the pulse is almost invariably feeble and empty, while in chlorosis it is often dull and even of quite excessive pressure.

The type of anemia under discussion is probably due to

(1) Excessive demand on, or actual destruction of the blood elements.

(2) Deficient renewal of its elements.

(3) Or both.

The first is a sequence of some disease like fever or toxemia, the second of inanition or malnutrition, and the third of some wasting process, which not only depreciates the blood, but by lowering functional activity militates against any physiological tendency to restoration.

In any instance the paramount need is to stimulate hematopoiesis, and for immediate and satisfactory effect in this direction Pepto-Mangan (Gude) had been found of very great value. Under its administration, the hematogenic function is actively increased.

and the appetite and general nutrition rapidly raised. The digestion is improved and never embarrassed—a statement that can be made of none of the inorganic preparations of iron.

It goes without saying that the best of hygiene, good food and as much outdoor life as possible should also be prescribed in the treatment of puberal anemia. The condition if allowed to continue is always dangerous, principally because of its predisposing tendencies to graver disease; but the results of the treatment recommended are usually so prompt and decisive that there is rarely any excuse for its not being controlled. At any rate, "It is the stitch in time" that saves serious trouble, and Pepto-Mangan (Gude) in this class of cases will be found a very dependable stitch.

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Morphine given in a dose of 0.015 subcutaneously at the beginning of the dilatation period delays the birth by lengthening the pauses and shortening the pains. The muscle pressure is also decreased; This effect appears after one half hour and lasts for three and a half hours. On the other hand, morphine given in doses from 0.015 to 0.02 at the end of the dilatation and during the expulsion period has practically no effect on the progress of the birth.

asenius Archiv bii. Gynecologie Vol. 84, No. 3.



## Journal Files Wanted.

The library of the Clinical Department of the School of Medicine of the University of Kansas needs the following Journals to complete volumes. The library committee would welcome the contribution of other standard Journals and books also. Ship them to Dr. G. H. Hoxie, Kansas City, Mo., whence they may be most easily transferred to Rosedale, Kans.

### Missing Numbers of Medical Journals.

#### JOURNAL OF AMERICAN MEDICAL ASS'N.

- 1907 Vol 48 Nos. 4, 14, 17, 19, 22, 25, 26  
 1906 Vol 47 Nos. 14, 17, 18  
 1906 Vol 46 Nos. 11, 15  
 1905 Vol 45 No. 23  
 1904 Vol 44 Nos. 2, 11  
 1904 Vol 42 Nos. 2, 7, 13, 15, 20, 24, 26, 27  
 1903 Vol 41 Nos. 1, 2, 3, 4, 5, 9, 10, 19, 20, 22, 23, 25  
 1902 Vol 38 Nos. 7, 8, 10, 16, 20  
 1901 Vol 36 Nos. 1, 2, 3, 6, 7, 9, 10, 11, 12, 13, 14, 16, 18

#### JOURNAL OF NERVOUS AND MENTAL DISEASES.

- 1906 Vol 33 Nos. 5, 6.

#### AMERICAN MEDICINE

- 1906 Vol 12 Nos. 10, 11, 12

#### LANCET (LONDON)

- 1907 Vol 1 Nos. 1, 2, 3, 4, 6, 8, 10, 12, 16, 18, 20, 22, 24

#### FOLIA HAEMATOLOGICA

- 1906 Vol 3 Nos. 1, 2, 9

#### ANNALS OF GYNECOLOGY AND PEDIATRY

- 1905 Vol 18 Nos. 1, 8  
 1906 Vol 12 No. 1  
 1907 Vol 20 Nos. 4, 7, 8, 9, 10, 11, 12

#### PRACTITIONER

- 1906 Vol 76 No. 1

#### DERMATOLOGISCHES CENTRALBLATT.

- 1906 Vol 10 No. 1

## SURGERY, GYNECOLOGY AND OBSTETRICS

1906 Vol 11 Nos 1, 3, 4

## AMERICAN JOURNAL OF MEDICAL SCIENCES

1903 Vol 133 Nos 5, 6,

## AMERICAN JOURNAL OF OBSTETRICS

1905 Vol 52 No 6

1906 Vol 53 Nos 1, 2

1906 Vol 54 Nos 2, 3, 4, 5, 6

## BOSTON MEDICAL AND SURGICAL JOURNAL

1905 Vol 153 No 1

1907 Vol 157 Nos 24, 25, 26

## NEW YORK MEDICAL JOURNAL

1895 Vol 62 Nos 7, 8

1896 Vol 63 Nos 20, 21

1896 Vol 65 All nos

1897 Vol 65 All nos

1897 Vol 66 All nos

1898 Vol 67 All nos

1898 Vol 68 All nos

1899 Vol 69 All nos

1900 Vol 71 All nos

1900 Vol 71 All nos

1900 Vol 72 All nos

1901 Vol 72 All nos

1901 Vol 73 All nos

1901 Vol 74 All nos

1902 Vol 75 Nos 1, 2  
3, 4, 5, 6, 7, 8, 16

1902 Vol 76 No 20

1903 Vol 77 All nos

1903 Vol 78 All nos

1904 Vol 76 All nos

1904 Vol 80 All nos

1905 Vol 81 All nos

1906 Vol 83 Nos 24

1906 Vol 84 Nos 22  
53, 241907 Vol 84 Nos 22,  
23, 241907 Vol 85 Nos 21,  
241907 Vol 86 Nos be-  
yond 7

## THERAPEUTIC GAZETTE

1897 Vol 21 All no

1898 Vol 22 Nos 1, 2, 3, 6, 9, 10

1899 Vol 23 Nos 4, 5, 6, 9, 10

1900 Vol 24 Nos 2, 5, 8, 10, 13, 7

1901 Vol 25 All nos

1901 Vol 26 Nos 1, 3, 4, 5, 6, 7, 12

## THE JOURNAL OF THE

1903 Vol 27 Nos 1, 4, 6, 9, 10

1904 Vol 28 Nos 2, 4, 5, 8

1905 Vol 29 Nos 1, 3, 5, 8, 9

1907 Vol 31 Nos beyond 5

## THE POSTGRADUATE (N. Y.)

1904 Vol 91 Nos 1, 2, 3, 4, 5,, 7, 8, 9, 10, 11, 12

1905 Vol 20 Nos 1, 2, 3, 4, 5,, 6, 11

1906 Vol 21 No 10

1907 Vol 22 Nos 6, 7, 8, 9, 10, 11, 12

## AMERICAN JOURNAL OF DERMATOLOGY

1907 Vol 11 Nos 6, 7, 8, 9, 10, 11, 12

## MEDICAL RECORD

1883 Vol 23 No 6

1889 Vol 36 No 11

1896 Vol 50 Nos 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 18  
19, 21, 24

1807 Vol 51 No 1

1899 Vol 55 No 12

1899 Vol 56 Nos; 21, 22, 23, 24, 25

1901 Vol 59 Nos 3, 5, 7, 18, 22, 23

1901 Vol 60 No 26

1902 Vol 51 No 22

1902 Vol 62 Nos 2, 4, 5, 6, 8, 10, 11, 14, 15, 16, 18, 19,  
21, 22

1905 Vol 67 Nos 24, 25, 26      1907 Vol 71 No 10

## ARCHIVES OF PEDIATRICS

1906 Vol 23 Nos 2, 3, 4, 5, 6, 7, 8, 9, 10, 12

## BULLETON OF JOHN HOPKINS HOSPITAL

1996 Vol 17 Nos 4, 6, 7, 8, 9, 10,, 11, 12

CENTRALBLAT ALLGEMEINE PATHOLOG PATHO-  
LOGANAOMIE

1905 Vol 16 No 1

## MEDICAL REVIEW OF REVIEWS

1906 Vol 12 Nos 5, 4,      1907 Vol 13 Nos 8, 11, 12

# THE JOURNAL

## OF THE

# Kansas Medical Society.

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Vol. XIII.

KANSAS CITY, KANSAS, MAY, 1908.

No. 5

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### CHRONIC MYOCARDITIS.

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#### Some Remarks on Its Pathology, Symptoms and Treatment.

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By FRANK A. CARMICHAEL, M. D., Goodland, Kansas.

\* Read Before the Western Kansas Medical Society, Colby, Kas., March 18, 1908.

The frequent occurrence of sudden death from heart lesions in those who have apparently enjoyed robust health and in whom the presence of such disease has been unsuspected, the great diversity of contributing etiological factors and the too frequent paucity of autopsy findings, contribute to excite the interest and prompt a more painstaking and closer study of a type of cardiac disease so frequently latent as to symptoms, but so appallingly sudden in the exhibition of its lethal power.

It is to be regretted that the past few years have contributed so little toward an advancement in the pathology of the type of myocardial degeneration, known as myo-fibrosis. While several very able papers have been contributed on experimentally produced myocardial lesions, they have not materially contributed to a more thorough comprehension of their pathology and while the pathology of endocardial lesions is at present the time amendable to a fairly definite classification and a correspondingly definite symptomatology, the mechanism of fibroid degeneration is still veiled in obscurity.

It has been observed that in cases that have died suddenly from heart failure that not only has the pathology of the heart muscle varied within wide limits from those exhibiting pronounced fibretic changes and extensive areas of degeneration, to those in which macro- and microscopic inspection alike fail to demonstrate a process sufficient to cause death—in which, in fact, the heart is without evidence of any diseased condition. It is these facts, the



lack of physical confirmatory symptoms and frequent latency of the condition that arrest the attention and invite the interest of the student in these processes.

In a majority of cases coming to autopsy following sudden death from myocardial disease of the chronic type, evidences of degenerative arterial changes are present. In fact, it may be said that endarteritis, atheroma and arteriosclerotic changes both diffuse and nodular accompany myocardial disease with such frequency as to be almost looked upon as an integral part of the general process, but in a considerable number of cases, they are not present while the absence of change in the myocardium in cases of pronounced arterial degeneration is frequently noted.

As to the nature of the myocardial change itself, the opinions of pathologists vary. It would seem that a consensus of these, however, regard the term "myocarditis", as used in a general sense, a misnomer. Inasmuch as evidence of an inflammatory process per se are usually wanting, the condition may be looked upon as purely degenerative, neither conservative nor protective except from a relative standpoint and is in all probability, initiated by an ischaemia of the heart musculature primarily due to arteritis of the coronary vessels.

The natural tendency of any tissue deprived of sufficient blood supply is toward degeneration, which in the heart, must result in impaired dynamic efficiency as it is never permitted to rest or relax, naturally resulting in a dilation resembling primarily physiological relaxation of the muscles.

The conservative forces of nature have determined that the blood supply is insufficient to nourish the heart as a purely muscular organ, are forces to permit certain degenerative or metaplastic changes whereby certain groups of muscle fibres undergo sclerotic changes, and are supplanted by a type of tissue that is non-participating in the vital functions, requiring a minimum of nutritional supply thus evidencing the effort of nature to reduce the amount of muscular tissue to that which may have an efficient blood supply.

While the heart exhibits an increase in size macroscopically, there is a relative diminution in dynamic force or in actual contractile muscular tissue. And arteritic processes in the coronary arteries are usually subacute or chronic in character resulting in gradual narrowing of the vessel. This is most commonly manifested in the anterior coronary artery as a slow obliterative process in the trunk of the vessel, or by occlusion of its opening by atheromatous plaques in the aorta, or its manifestation may be sudden and fatal from embolism or thrombosis occurring in a nar-

rowed vessel and favored by a sluggish current or heightened blood pressure caused by diminished caliber of the vessel. The anterior coronary artery being longer, smaller, and more tortuous as well as more active than the posterior, is most frequently involved, therefore the parts directly supplied by this vessel, i. e., the left ventricle, interventricular septum and papillary muscle show the greatest and most constant pathologic changes.

In cases exhibiting more acute coronary obstruction, the condition which Zeigler has described under the term "Myomalacia Cordis", occurs. In this condition, the heart becomes rapidly ischaemic pale yellow in color and irregular areas exhibiting necrotic changes occur which are swollen and prominent. The degeneration of the muscle fibres is rapid and marked, they become fragmented and their nuclei disappear, sudden and alarming symptoms of dilatation and insufficiency appear.

Sudden death is the rule in these cases but in those who recover the necrotic area is replaced by a tissue resembling connective tissue which may resemble the terminal product of an inflammatory process, but which must be regarded as a sclerosis or dystrophy as the evidence of inflammation is wanting.

The occurrence of true chronic myocarditis following acute inflammation of the myocardium primarily due to the toxemia of acute infection may be conceded. Whether acute myocarditis itself is due to the direct action of toxins on the heart muscle, or to acute arteritis, as taught by the French schools, is a mooted point, but as Koester has found that myocarditis may occur from uncomplicated valvular lesions, in which the compensation has been disturbed, and in which he has attributed the lesion to dilatation, we may accept the theory of Dehio that myofibrosis is a result of dilatation, this dilatation resulting in a lengthening of the blood channels and a mechanical lessening of their caliber.

As to the causes operating in the production of compensatory failure, opinions again differ.

Saltykow (Virchow's Arch. band. clxxxli) considers the fibrous deposits the direct results of old infarcts from disturbance of the myocardial circulation. Dehio and Krehl have attributed the failure of compensation to deposits of connective tissue between the muscle fibres which not only weaken the muscular structure, but mechanically embarrass the contractile power of the heart. This view, however, is not sustained in all cases by the autopsy findings and is disputed by many able pathologists as shown by Gennari (Arch de le sci. med. Dec. 1905).

If one were to accept the theory or the myogenic origin of the

hearts activity, that impulses governing its action originate in the bundle of His, the mechanism of sudden cardiac failure might hypothetically be ascribed as due to invasion of this area by sclerotic processes and interference with the conductivity of motor impulses, resulting in the dreaded asystole.

The analogy of the pathogenesis of myofibrosis with the Stokes-Adams syndrome holds good even from the view point of those who contend that the latter phenomena is due to sclerosis of the vessels of the bulb.

For instance, age, sex and manner of life form an etiological standpoint; the cardiac and arterial degeneration with special reference to involvement of the interventricular septum, which contains in part, the bundle of His, from a pathologic, the suddenness of the attacks preceded by pallor, muscular relaxation, syncope and almost complete cessation of the heart's action typifying a case of sudden death from cardiac failure, from a symptomatic, are truly striking, only in the one consciousness does not return and the contractile impulse being too long delayed or utterly suspended, the heart's action is immediately and permanently arrested, while in the other, its function is but temporarily inhibited and is resumed after a short interval, though its rythm is disturbed, resulting in pronounced bradycardia and auricular fibrillation.

As the first attack of angina pectoris may terminate fatally or if not, is regarded merely a symptom of myocarditis, so the primary shock of heart block to the cardiac innervation may result in sudden death, or, if recovery occurs, may be regarded more as a symptom of myocardial change than as a definite pathological entity. In view of the fact that our present knowledge of the mechanism of sudden death in myocardial degeneration without rupture is practically nil, this conclusion tentatively reached might appear tenable.

A study of the symptoms of this condition is one of vital interest, inasmuch as early regulation of the patients' life and habits may avert a sudden fatality. The physician is handicapped by the fact that so many cases are latent and are never even suspected until some sudden strain or excitement results in sudden failure and death.

On the other hand these cases that come under observation are usually merely characterized by symptoms of chronic cardiac insufficiency without, as a rule, defined symptoms pointing to involvement of the myocardium.

The symptoms directly referable to the heart are feelings of precordial oppression, or dull pain, frequently with true anginal

attacks, disturbance of compensation resulting in breathlessness on slight exertion, slight cyanosis due to interference with the pulmonary circulation, bronchitis, hydrothorax, pulmonary oedema and dyspnoea or orthopnoea frequently of nocturnal type. To these are frequently added a train of marked digestive disturbances.

Embolism and infarction are common in mixed lesions. I recently observed a case in which the clinical symptoms of splenic infarction occurred twice and in whom the right radial pulse was totally obliterated for six weeks before the final termination.

It may be safely said that an absolute diagnosis is seldom arrived at during life as the symptoms are vague and inconclusive and those of fatty heart, pericardial adhesions and occasionally valvular stenotic lesions simulate it so closely as to permit only of a tentative diagnosis.

The conditions which may be said to favor a diagnosis of chronic myocardial change are in the order of their importance.

a. Arteriosclerosis whenever found if accompanied by symptoms referable to the heart in the absence of phenomenon pointing definitely to endocardial involvement.

b. Dyspnoea and evidence of pulmonary stasis if unaccompanied by murmurs that can positively be identified as valvular (though murmurs due to relative mitral or aortic leakage may be present from cardiac or aortic dilatation and require close study before they may be excluded).

c. The relative strength of the aortic and pulmonic second sounds. These sounds are the most constant in their alteration and may really be considered of value from a differential stand point.

While the heart tones are modified not alone by incidental murmurs, due to dilatation and relative valvular insufficiency, but also by alteration in blood pressure and disturbances of co-ordination of the heart muscle, though in some cases the heart tones may be clear throughout and are usually so in the inception of the process, faintness of the second aortic and accentuation of the second pulmonic have been noted with such constancy as to be regarded as characteristic of this type of lesion.

d. Blood pressure depends entirely on the state of compensation but is usually high because of arterial involvement.

e. The variability of the pulse makes it of slight value in determining the character of the lesion. In many cases there is arrhythmia of a paroxysmal type. Persistent bradycardia may be observed throughout and when accompanied by syncopal attacks is highly suggestive though not conclusive. In many cases (Ebest,



eim) a regular pulse may be present while rapidity prevails in a majority of cases.

f. The cardiac reflex of Abrams is not elicited in the advanced type.

A contemplation of our present methods of treatment is by no means satisfactory. There seems to be no direct treatment of the established conditions, whatever of therapeutic effort has been expended seems to have been directed toward the correction of the most common causal factor, i. e. arteriosclerosis.

As has been stated, in reviewing the pathology of this condition, arteriosclerosis, while a very frequent accompaniment of myocarditis, is by no means always demonstrable nor is it, except with references to the coronary arteries, essential, nor does its demonstrable presence in peripheral vessels determine myocardial disease as existing.

This uncertainty with the fact that the iodines, which seems to constitute the main stay of treatment in this condition when administered for long periods and in proper dosage has utterly failed to produce any favorable change in the arterial condition in many cases, but on the other hand, has frequently augmented the distressing gastric symptoms so often present, would lead us to suspect its employment as empiric rather than rational.

Digitalis, one of the most dependable as well as one of the most abused drugs in our armamentarium, is of doubtful value. Some urge its use in the early stages, nearly all concur in the opinion that its employment in advanced myocardial change is contra-indicated and especially so if bradycardia and high arterial tension is present.

Some authors have advocated its administration in combination with the nitrites, though the justification of this method is somewhat obscure.

It has been shown by McKenzie (British Med. Jour. Mch-Apr. 1905) that its action is that of a universal depressant of all the heart functions, and that its action and effect is due to the fact that it is a direct muscle poison.

Its administration in very moderate doses has frequently produced death according to Duroziez, who produced a series of cases in proof of this assertion.

Goepp (Am. Med. Sep. 3, '03) considers its administration absolutely contra indicated in all stages of the disease.

It would seem that the administration of such a drug with its well known toxic action and cumulative tendencies would be hazardous if continued for long periods. On the other hand, the almost constantly increased blood pressure existing in these cases would in-

dicating the exhibition of the nitrites for long periods and increasing doses: if tolerance seems to be established, combined with physical and mental rest and such dietary and hygienic measures as will contribute to the greatest physiologic rest to the overworked heart.

Under this treatment alone, the dilatation which may be considered a primary and very probable predisposing factor in the production of tissue changes in the myocardium, may be combatted.

In the treatment of this condition as in all others of obscure pathology, some very fantastic methods have been exploited. This is strongly evidenced by Heitz (*Lyon Medicale* Dec. '05) on the revival of the carbonic acid bath in the treatment of myocardial disease.

While such a method of treatment might exert an evanescent effect upon the size of the heart when dilatation is not extreme, or when the element of hypertrophy is not present, the probability of a permanent benefit is extremely slight, and even if pronounced benefit were to accrue from its employment, it is so difficult to apply to most cases that its practical employment could seldom be accomplished.

In commenting on Schott's use of the warm carbonated brine baths, Thompson (*Practice* 1900) says, "It is claimed for the Nauheim treatment that it lessens the area of cardiac dullness slows and strengthens the pulse and respiration and relieves local congestion in lungs, liver and other organs" (all of which may be achieved by the simple warm bath) "general arterial pressure is raised and the skin and peripheral circulation stimulated".

The method of Schott of strengthening the heart by carefully graduated exercises is rational and is brilliantly successful in some cases, but it has the objection of being unscientific inasmuch as the strength and re-cuperative capacity of a given heart are unknown quantities, and even after apparent progressive improvement for a time the heart may rapidly fail or sudden death supervene. The method is not available for general practitioners, as it should be employed only under the direct supervision of the physician in those cases where its employment is demanded.

The indiscriminate use of cardinants in these conditions cannot be too strongly condemned. It would be just as logical to apply the whip to an overworked and exhausted horse without lightening his burden, as to attempt to relieve an overworked heart from myocardial disease by any drug calculated to stimulate its action except perhaps to tide over a brief crisis. The employment of drugs to strengthen the heart's contractile force results only in an increased blood pressure and increased expenditure of cardiac energy.

What the overworked animal needs is rest, and a lightening of

his load. What the weakened and over taxed heart needs is the same, there is no difference in the principle.

At first glance, the administration of depressants as aconite and veratrim in weakness and irritability of heart would seem to invite disaster, yet in many of these cases showing progressive failure of the heart muscle with irritability small doses of these frequently result in the amelioration of symptoms that would be augmented by the use of cardiac stimulants.

Remarks relative to the prognosis of this condition seem uncalled for.

It is usually unfavorable uncompromisingly so to ultimate recovery though regulation of habits and manner of living may prolong life. It may be said that the prognosis is relatively more favorable in elderly than in youthful patients, partly because the habits of the former are more quiet and the heart is able to meet the demands of the condition of physical decadence.

In youthful subjects it is less able to meet the requirements of a vigorous body with the frequent sudden muscular demands made upon it.

Added to the prognosis of uncompensated valvular lesions, the extra hazard of deteriorated heart muscle and the numerous conditions that attend it such as angina pectoris, heart rupture, cerebral anaemia or coronary occlusion must be considered.

The most trifling intercurrent affections may prove fatal. In my experience, those cases exhibiting marked gastric irritability pursue a rapid and uniformly fatal trend.

Carefully reviewing the entire subject the following conclusions in brief seem justified.

First—While many diseases, age, sex, habit and mode of living may be regarded as possible etiological factors in the production of myocardial disease of fibroid type, they are not essential, as its occurrence independent of any determinable predisposing cause is so frequent as to show conclusively that its origin may be independent of such factors.

Second—That the mechanism of these changes in the heart muscle has not been clearly defined, but it is more or less a theory and hypothesis requiring closer observations and a more thorough study of their method of production.

Third—That arteriosclerosis of the peripheral trunks in heart lesions, may not be accepted as a presumptive evidence of disease of the myocardium except in such cases as admit of absolute exclusion of endocardial implication, and even in such, its existence may be considered as only of presumptive value.

Fourth—That the mechanism of sudden death in these cases (exclusive of rupture) must be due to sudden and absolute inhibition of contractile impulse resulting in asystole, and that its manifestations exhibit so close an analogy to those of the Stokes-Adams Syndrome, as to permit a reasonable assumption that the same pathological process governs both phenomena, which assumption is so far sustained by the similarity in pathological findings.

Fifth—That fibrotic changes may be considered as a result of a cycle of three events.

(a) Sclerosis of the coronary arteries resulting in deficient blood supply, I. E. anaemia of the heart.

(b) Dilitation the direct result of anaemia from weakening of the heart muscle.

(c) Fibrotic change due in part to the primary coronary arteritis and in part to the dilitation which lengthens the course and diminishes the caliber of the cardiac vessels.

Sixth—That fibrotic changes, when once established, are permanent with a tendency toward progression, are uninfluenced so far as known by any method of therapy so far as the established changes are concerned, but under proper hygienic conditions in their earlier stages, progressive tendencies may be overcome.

Seventh—That symptoms when present are so vague and may be applicable to so many other cardiac derangements as to afford merely presumptive grounds for a diagnosis.

Eighth—That the use of all cardiants in general and digitalis in particular, that stimulate the contractile power of the heart without lessening the peripheral resistance, are ill-advised and irrational and tend rather to favor than to arrest the progress of the lesion.

Ninth—That opium as advocated by Mussur is one of the most valuable remedies at our disposal in cases where the condition of disturbed compensation give rise to nervousness and apprehension, acting as a tonic to the heart, reducing peripheral resistance quieting nervous tendencies, steadying respiration, allaying dyspnoea and giving necessary mental and physical rest.

Tenth—In view of the favorable reports from the use of cardiac depressants in selected cases, the cautious exhibition of such drugs as aconite and veratrim is justified if administered to small doses and their effect closely watched, as there are undoubtedly cases that experience distinct benefit from their administration.



## SURGICAL TREATMENT OF DETACHED RETINAE.

By G. W. MASER, M. D., Parsons, Kansas.

Read Before the Medical Society of the Southwest.

Four years ago I reported at the Wichita meeting of the Kansas State Medical Society, a case that had been operated upon for detachment of the retina, with the result of restoring sight. This case has remained cured, the sight remaining good to the present time, and must be regarded as a permanent cure.

This year I have done the operation six times on two cases. These cases were of more than ordinary interest on account of the number of operations made on two eyes before reattachment was secured. The conclusions reached were that we should not be discouraged by a failure from a single operation, but should make a number of them, should a failure or partial success be the result of the first. Again, the site of the operation is so far removed from the important eye centers, that is, the ciliary region, that the danger is reduced to the minimum. With ordinary care, the danger is not nearly so great as would attend an operation for cataract, or even an iridectomy.

The results of the treatment of detachment of the retina have been most discouraging, the cures, if any, have been spontaneous and not the result of any form of treatment. A careful research of the literature on this subject fails to describe the operation as made on these cases, the report of which follows in this article.

I do not claim priority for this operation. It has been copied from the operation made by Mr. Lang, of the Royal Ophthalmic Hospital, England. The results have been so encouraging that the method should become more widely known to the ophthalmologists of this country.

Mr. Lang had operated on two cases, the operations being in the nature of an experiment, while at the same time not subjecting the patient to any risk as they were practically blind, and no other plan of treatment offered any chance of success.

The result of the operation on the above two cases I do not know, on account of the short time I had of observing them.

The class of cases operated on must be selected. No good results would be expected from a detachment caused from a tumor, be it benign or malignant. The operation could only be successful where the detachment was caused by the pressure of serum between the retina and choroid, and before the retina had lost its function.

Just how long the retina will retain its function after detachment, is not known, but in one of my cases the operation was made in four years after the diagnosis of detached retina, with considerable improvement in sight.

This leads us to recommend operative treatment of detachments of long standing, if there is fair light perception.

The causes of detachment are, as a rule, obscure. Aside from those caused from traumatism and tumors of different kinds, as a general rule no cause can be found, and whatever theory is advanced remains only a theory, and the pathologist has still to find the real cause. When this is found, we may determine the proper medicinal treatment. We do know that it is more common in males than females. It is more frequent in myopic eyes, owing to the stretching of the choroid and sclera. Some authors state that more than fifty per cent of the cases occur in myopes. It may be found in cases of general debility, when the entire system is weakened from whatever cause.

Various methods of treatment, both medical and surgical, have been tried, but the results have been disappointing. Most cases have been treated by the use of diaphoretics, chiefly pilocarpine, administered hypodermically, together with bandaging the eyes, and the recumbent posture. Setons, blisters and leaches have been used with little or no success. As far back as 1859 Sichel introduced the plan of tapping the subretinal fluid by a puncture of the sclerotic and choroid.

In 1863 Von Graefe recommended discission of the retina, in three years had employed it fifty times, but had no lasting benefit in a single case.

De Wecher, in 1877, tried to keep up a continuous drainage of the subretinal fluid by passing a fine gold wire through the sack and leaving it in position, thinking the retina would become re-attached, but in place of good results, he found that this treatment sometimes caused sympathetic disease in the other eye.

In 1890, Galezonski recommended the plan of entering a catgut beneath the retina and stitching to the choroid. This plan was a failure. The same author tried aspiration with a syringe, but the plan was a failure. He also tried an iridectomy without success.

Deutchman, in 1895 proposed the operation of cutting with a double edged knife, the sclera, choroid, and retina, into the vitreous space, pushing it to the opposite side of the eyeball, cutting to both sides. His aim was to divide any adhesions or bonds that

might be formed in the vitreous body. No statistics are given of the result of this treatment.

Fox, in his work on the eye, reports no cures by any method of treatment.

Norris and Oliver report 789 cases, with no cures by surgical treatment, and only two cases regaining function by medicinal treatment.

Noyes, Juler and De Schweinitz report no cases cured from operation, neither does Mittendorf.

Roosa reports improvements in some cases, but recommend operative treatment only after other treatments have failed.

Nettleship does not report cases cured by operation but recommends it in recent cases.

Ball reports cases cured by Staerkle of Basel, by means of injections of salt solutions, the strength being from 2 to 10 per cent. He treated twenty-three cases, having improvement in twenty cases and complete reattachment in three.

Dor of Lyons, claims fourteen complete recoveries in twenty-one cases, using a 20 per cent salt solution. The author does not state whether the injections were made in the vitreous or not.

The operations that I have made were for the purpose of creating a ragged wound in the retina to produce inflammation, with exudation enough to unite the retina to the choroid. Following the operation, the eyes are bandaged and the patient is to lie quietly in the recumbent position for about one week.

The different steps in the operation are, a triangular flap is made in the conjunctive at a point between the attachment of the recti muscles. After the hemorrhage has ceased, and the clear sclera is seen, a Von Graefe cataract knife is pushed through the sclera, choroid and retina, well into the posterior chamber, then, by turning the knife slightly, the serum is allowed to escape. When the serum is drained, by using the point of puncture as the fulcrum, the retina is further incised. Turning the knife as near to the right angle as possible, the retina is again incised. In this way considerable inflammation follows. This is exactly what is desired, and has been followed in all my cases by a reattachment at the point operated upon, but not of the entire retina. That part at some distance from the operation has failed to unite when the separation has involved more than half the retina. A second operation is made after the eye has become quiet and the tension normal. In some cases a third operation has been made before complete union has been established. In no case has there been any dangerous inflammation.

It would seem from the foregoing operations, that the ophthalmic surgeon would be justified in reoperating until the reattachment was complete.

The first case I operated on was five years ago. This man was 25 years old, and had recently recovered from an attack of mountain fever, was convalescing slowly, when, without any symptoms referable to the eye, found he was blind in the right eye, vision being reduced to 1-200. Ophthalmoscopic examination showed a detachment at the lower third of the retina. The operation was made two weeks after the detachment occurred. His vision three months later was 20-30 and has remained good since that time.

Another patient, Mr. H., age 42 years, occupation coal dealer, had been blind in the right eye for about six years. Had a divergent squint in this eye, pupil normal. Had some kind of an operation made on this eye in Omaha. What was done the patient does not know. The ophthalmoscope showed a detachment of the lower half of the retina. Could see a light when held directly in front of the pupil, but not when held above the pupil.

About six weeks previous to his consulting me, the patient began to see black spots in front of the left eye. Sight in this eye remained good till several days before he came to me. Could see as well as usual one day, and the next day was unable to recognize his friends or attend to his business. Ophthalmoscopic examination showed a detachment of two-thirds of the retina, mostly on the temporal side. Patient was unable to see the flame of a candle when held on the nasal side of the eye, and could count fingers at two feet. Tension normal.

January 30, 1907, the first operation was made on this eye, and one month later he could count fingers at fifteen feet. The retina was attached at the point operated on, but some detachment remained at a lower level. Another operation was made February 16th. This was followed by an increase of vision to 20-200. On May 11th there still remained a small detachment at the lower part of the retina, and the third operation was made. On July 8th, the examination showed a perfect reattachment of the entire retina, the vision being 20-100. At this time an operation was made on the right eye, followed by improvement in vision from perception of light only, to the counting of fingers at six feet. September 27th examination showed retinal bloodvessels small, blood supply deficient and one-third of the retina detached at the lower part. A second operation was made on this date, and on October 1st, the sight had doubled.

The third case, Mr. F., age 53 years, occupation real estate



agent, suddenly noticed that he could not see with his right eye. Thinks the trouble came on in the night. Had a detachment of the upper third of the retina. There was no exciting cause found in the history. The man was in good health generally and had fair light perception at the lower and inner portion of the eye. First operation was made on May 15th, 1907. On the 23rd the vision was 20-100. Some detachment remained on the 28th, when a second operation was performed. I did not see the case again until July 3rd, when the third operation was made on the small patch of detachment at the lower part. Examination with the ophthalmoscope on September 17th showed the bloodvessels of the retina atrophied. The retina was attached, with a small opaque patch at the lower part, the optic disc normal, vitreous clear, but the vision was reduced to fair light perception.

I am unable to form an opinion as to the cause of the poor vision. My experience has been most encouraging, having succeeded in restoring sight in three out of four cases operated on. The operation as made, promises good results, especially if made early, while the retina retains its function.



## RATIONAL TREATMENT OF PNEUMONIA.

By DR. J. D. WALTHALL, Paola, Kansas.

Read Before the Southeast Medical Society.

While it is the purpose to make this a practical paper, it will be necessary to review the subject in general to appreciate the conclusion.

Pneumonia is an acute, infectious disease of the lungs. Due to the invasion of a variety of bacteria producing an inflammation and pursuing a course more or less typical; and is manifested by a variety of symptoms due in part to the absorption of toxins from the lungs.

The name would indicate that it is a disease of the lungs but we could not study the subject in its entirety without considering its effect upon the other vital organs.

Croupous, fibrinous, interstitial, and lobar-pneumonia are differentiated from catarrhal bronchitis, broncho and lobular-pneumonia by the character and location of the inflammation. It is estimated that 7% of all deaths are from pneumonia which outranks tuberculosis in its rate of mortality.

As a matter of statistics I would call attention to a clipping

from the Kansas City Times of February 15th., entitled Deaths in Topeka Last Year. "The total number of deaths here last year was 670. Pneumonia and organic heart disease shared first honors in reaping the harvest of death. Each of these diseases caused sixty deaths. This is the showing made by the vital statistics for the year collected by J. D. Pattison, sanitary sergeant, for the state board of health. Tuberculosis of the lungs comes next with forty-nine deaths. Diphtheria claimed thirty-one victims. Senile debility caused thirty-eight deaths."

The most potent predisposing causes, are unhygienic surroundings, previous disease, old age or alcoholism.

The exciting causes would be anything that would lower the resistance of the body against the invasion of disease germs, such as fatigue, irregular meals, loss of sleep and exposure to sudden or continued cold.

The pneumococcus, the pneumobaccillus and the diplococcus pneumoniae are to be found in the lungs and other fluids and tissues of the body.

According to "Netter" these bacteria are to be found in the mouths of 20% of healthy individuals.

The different stages of pneumonia are engorgement, hepatization, and resolution, in the first there is a combination of congestion and oedema, when the lungs become distended, heavy and of a dark red color, produced by injected capillaries, swollen epithelial cells and an acclued alveoli. This stage usually lasts about 24 hours but may continue for several days.

In hepatization the lung presents the appearance of the liver and is increased in weight three or four times, this stage usually begins on the second or third day. subsides after the crisis, and is followed by resolution, but if the consolidation be too long continued or the inflammation too severe, due to putrifactive bacteria, there is death of the part and an abscess is the result.

Syptoms: The onset is usually sudden, ushered in by a chill, followed by high temperature, which may be preceded by a nasal or pharyngeal catarrh and slight malaise.

This may or may not be accompanied by pain as the inflammation approaches the pleura.

Dyspnea is another important initial symptom due to the pain and to the engorged condition of the lung, suggested by a frothy, bloody, vcid, sputum. Coarse, fine, moist and dry rales, can be heard over the affected parts. The cheeks are flushed, skin dry and hot, expression anxious and the pulse frequent, full and strong:

there is headache, backache, loss of appetite and thirst, scanty high colored urine and constipation.

Resolution generally takes place from the fifth to the eighth day though it may come sooner or later.

The temperature falls by crisis or lysis, during which the patient perspires freely and the general conditions improve fast.

Physical Examination: We usually find the patient on his back or affected side in case of pain, his nostrils expanded on inspiration, his lips and nose purple, features swollen, and very restless.

The chest has less expansion and the intercostal spaces are very apparent the abdominal breathing is increased, the percussion note of the congested lung is quite as resonant as usual or may be tympanitic. The hepatized lung shows a dullness or may show a high pitched tympanitic sound if the consolidated lung is separated from the chest wall by air.

After the crisis, resonance reappears although it may be delayed several days, while the patient is convalescing favorably.

On auscultation, during the period of congestion, coarse and crepitant rales are to be heard.

As the lungs becomes consolidated, the crepitant rale is replaced by bronchial breathing, bronchophony and sometimes egophony.

These accidental sounds are replaced by the "Crepitus Redux" or moist rales.

The condition of leucocytosis indicated the course and severity of disease.

An increase of the number of leucocytes indicates an invasion of the disease in new area while a diminution fortells the crisis.

Thus far this paper has dealt with idiopathic cases of pneumonia and touched on the symptoms of the other organs involved, but frequently the attack on the lung is secondary to other diseases, the variation in characteristics is explained by different bacteria producing the inflammation.

Pneumonia occurring in typhoid and malarial fevers, erysipelas, septicaemia and in various other infectious diseases, shows the same infection as characterize the disease it complicates.

This class of cases follows no type, is subject to the disease of which it is secondary and may last but a few hours: on the other hand resolution may be slow, suppuration frequent and attended with a great mortality.

Ephemeral or abortive cases are those that terminate in convalescence in four or five days.

Case: Child eight years old, complete engorgement, temp. 103 pulse 140, respiration 44, No thoracic breathing, active stimulation general and local: corrected nearly all the symptoms in 24 hours.

The diagnosis is ordinarily very easy except in central pneumonia and in children. It is to be diffentiated from acute oedema by the absence of fever, general distribution of the rales and the associated cardiac disease. It may be mistaken for acute tuberculosis, but the history of the case would usally be sufficient. The presence of the bacilli and the protracted course of the disease would enable a diagnosis to be made, or it could be mistaken for acute pleurisy with abundant exudation, but the ordinary rules for physical examination of both diseases would make the diagnosis clear.

The prognosis is necessarily grave when we remember the number of vital organs involved.

According to Frankel and Reiche from 16 to 23% die, it is more favorable in children but in cases above 60 years it reaches 50 to 80%.

The rate is high as the percent of lung tissue involved.

A few cases die before the lung solidifies, but death usally comes just before the crisis is due.

Unfavorable symptoms are progressive, increased frequency of pulse and respiration, tracheal rales, prune juice sputum, coma, delirium and muscular tremor.

From this hasty review we see the self limited type of this disease.

In view of the various stages, the duration degree of severity of each, the rapidity with which the patients may pass from one to the other, the wide difference of treatment in each, the various effects of disease on the different types of patients, and many other peculiarities admonish us that the best results will be obtained from treating the patient rather than the disease.

I might impress this subject by pointing out a few common mistakes, it is true that antipyretics, heart sedatives blood-letting and etc., will relieve the symptoms of the first stage in most cases of the mic pneumonia, but it is a great mistake to continue this treatment throughout the disease.

The doctor who attended our family when I was a boy had no other treatment than veratrum, to maintain about the normal pulse rate, and strange to say a fair percent recovered. This was but a step in advance of the continued blood-letting till the patient died or recovered in spite of the treatment.

We have had other extremes carried to the extent of producing



results almost as bad. That stimulants are begun too soon and continued to produce toxic effects, there can be little doubt.

I saw a case of intoxication from alcohol in the second stage of pneumonia.

Dr. Green of Olathe reported a case which from too long continued use of digitalis produced death from paralysis of the heart in systole.

Recognizing the infectious etiology, its local effect on the lung and the corresponding involvement of the heart, the blood and the nervous system, and with an intimate acquaintance with the therapeutic agents, fulfilling the special indication of the pathologic symptoms present, would in my opinion constitute the rational treatment of pneumonia.



## SOME NOTES ON THE RECENT PREVALENCE OF SMALLPOX IN ATCHISON COUNTY.

By E. B. KNERR, M. D., Health Officer, Atchison, Kansas.

Read Before the Atchison County Medical Society, April 14, 1908.

Members of this society will recall that at the Effingham meeting in October 1, 07, I read a brief paper on the use of formaldehyde in the treatment of smallpox. I may say that the views presented in that paper as to the prophylactic and abortive action of formaldehyde on smallpox have been fully supported by subsequent observation. I am fully convinced that formaldehyde does have a preventive and delaying effect on the disease, but its influence is brief and only effective during administration.

The only known really effective preventive for smallpox is vaccination. I am fully convinced of this. In all cases where I could get a clear vaccination no smallpox developed, and almost invariably where vaccination was refused the disease went through the whole family.

In a family anywhere a case of smallpox developed all the unvaccinated who had been exposed took the disease, sooner or later, and usually in a light form where formaldehyde had been used faithfully, otherwise more severely. Children of unvaccinated parents and themselves never vaccinated, take the disease severely. Otherwise children as a rule have the disease very lightly. The only pitted child in over 300 cases that have come under my observation was a child of unvaccinated parents. Vaccination of parents undoubtedly attenuates the disease for their children born subsequent

to the vaccination. Fortunately for the children of this epidemic their parents had mostly been vaccinated because of previous epidemics.

But little or no pitting results from the prevailing form of smallpox. Of about 330 cases that have come to my observation since last May only two cases show distinct pitting, one the child of less than six months just referred to, and a student of Indian extraction at St. Benedicts College. The great majority show no evidence of the disease a week or two after convalescence. Some show reddish or brownish blotches usually somewhat indurated to the touch, and these disappear entirely in the course of a few months.

The discoloration yields promptly to applications of hydrogen peroxide.

No fatalities have occurred in this county, and no bad effects have been noted, with but one exception. In one case of the St. Benedict student who shows a slight pitting there appears a weakening of the subscapularis muscle and other attachments of the right scapula, which condition has arisen during his convalescence from the smallpox.

Whether this weakening is secondary to the disease may be questioned.

The most unfortunate circumstances of the present form of smallpox is the man imposed feature of it, the severe quarantine which the law demands: and next to this is the unwarranted prejudice which exists against the disease, in its present form at least.

The quarantine is bad because it is unnecessary and imposes upon the afflicted family needless hardships. With the quarantine the wage-earners of the family are detained and the family revenues are at once cut off. This is certainly an unjust imposition, especially in view of the fact that in all likelihood only the individuals actually having the disease can transmit it to others.

If such are isolated and the unafflicted are vaccinated and make pretty liberal use of formaldehyde as a daily disinfectant, there is no likelihood whatever of the disease being transmitted, and the well members of a family could come and go about their accustomed business with perfect safety to all their associates. Under such management the present form of smallpox is not so much to be feared as measles, for in vaccination we have an absolute preventive.

It should be most earnestly advocated that the state of Kansas have a compulsory vaccination law, not only for the benefit of the ones vaccinated but also for the modifying influence on the disease for the next generation. Also the quarantine requirements for smallpox should be modified to be no more severe than for scarle-

tina or diphtheria. Isolate the patient, disinfect everything that comes from him, vaccinate all other members of the family at once, but detain no one so long as he is well. Under universal vaccination the community would be vastly more secure from smallpox and the modified quarantine advocated would be a hardship to no one.

Even now without a compulsory vaccination law in Kansas, I would advocate the quarantine for smallpox be modified as above indicated, for it is a known fact that vaccination does prevent smallpox, and the privilege of vaccination is open to all as a voluntary matter. Should anyone refuse to be vaccinated it's his own concern if he wishes to run the risk of getting the smallpox, and if he contract the disease he surely has only himself to blame, having refused a clearly demonstrative preventive.

In many of the cases that have come to my observation the history of contagion is obscure. Still I am convinced that the disease is transmitted only by the afflicted, either by personal contact or by contact with some object that the afflicted have closely handled, such as bedding, wearing apparel, drinking cups, tableware, etc.

As a rule the victims protest that they have not the least idea where they could have been exposed. Some of these are wilfully ignorant, as I have subsequently learned. For instance, one young man could give no account of his contagion, but I learned by side investigation that two weeks prior to his eruption he had danced with a young woman of the Missouri side who at the dance was in the eruptive stage of smallpox. Another virtuous victim had been a Saturday night companion in a notorious rooming house of this city where some of the beds were infected.

And I have a suspicion that not a few cases of professed ignorance could have a true explanation in a like manner. A number of cases were spread from the schools, more particularly from the parochial than from the public schools. This is explained by the fact that vaccination was more general in the public than in the institutional schools.

By the way of summary I gather from the past year's experience with smallpox in about 330 cases in this county.

1st, that the present form of the disease is in no sense a dangerous one. There have been no fatalities and no serious sequelae in this county.

2nd, that the disease is transmitted only by the afflicted patients themselves personally or by close association with articles used by them; that an unafflicted second party will not carry the disease.

3rd, that vaccination is an absolute preventive to the disease.

4th, that the present quarantine law for the smallpox should be modified to require only isolation and detention of persons actually having the disease.

5th, that it should be generally recognized that the unvaccinated are alone responsible for the existence of smallpox, and the odium of the contagion should rest with them.





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**EDITOR.****J. E. SAWTELL,****ASSOCIATE EDITORS****CHAS. S. HUFFMAN.**


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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, Kansas City, Kansas.

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## EDITORIAL

That the personality of the physician has a great deal to do with the successful management of cases seems to be without question. The art of instilling confidence of his ability into the patient helps a great many cases and impresses them with the confidence of a successful termination of their disease. This is the whole cloth of Christian Scientists and when the physician has perfected himself in this art he has incorporated their art in his profession and robbed the Scientists of their armamentarium *sans* the idiotic features.



That the free clinics of the large cities robs the medical man of a great many pay cases is another fact which cannot be disputed. There are many cases taken care of by the free clinics that are abundantly able to pay. To get rid of this class of patients is a condition hard to be brought about. Some system of finding out the financial condition of so-called free patients will have to be evolved whereby the deserving and the undeserving can be placed in separate classes and justice given to all.

The Wyandotte County Medical Journal has been absorbed by the Journal of the Kansas Medical Society and the latter will hereafter be published in Kansas City, Kansas. The efforts of the present editor will be to make our Journal second to none of the State Journals of the Country. It is now the only medical journal published in the state and in the unifying of these medical interests good results should be obtained.



The physicians of this western country are slowly awakening to the fact that milk infection is the cause of a large per centage of the deaths from gastro intestinal disorders, tuberculosis, etc. This fact can be attested by the activity in some of the larger cities as regards milk inspection. St. Louis now has between 60 and 70 inspectors, examiners and board of health employes and the results obtained in procuring clean milk are gratifying. Kansas City is also providing for milk inspection on a large scale and it is only a question of time until the smaller cities will follow the example. When this mode of infection has been eliminated a great step in preventative medicine has been brought about.



**TRAVESTIES ON JUSTICE** are being enacted almost daily in the courts throughout the country. It seems that all a man has to do to clear himself after committing murder is to set up a plea of insanity and the jury promptly brings in a verdict of acquittal. The physicians in a large measure are responsible for this condition of affairs which places a premium upon crime. One has but to consult the records of many of the late murder cases to realize this appalling fact. The physicians are at fault, why, because they qualify as insanity experts and one set testifies for the state as to one condition and along comes another set whose testimony diametrically opposes the other with the result that the jury has to exclude the insanity experts testimony and settle the question for themselves. It seems ridiculous that a man should be adjudged insane who never before had exhibited any signs whatever of it, but simply during a heat of passion destroys the life of another. If this is insanity then it is the exception in place of the rule to find a person of sound mind. The only just and equitable way for the courts to help eradicate this evil is to appoint a commission of three or five experts on insanity and exclude all other expert testimony. The border line of insanity in some cases is so small that experts may disagree, but in the vast majority justice will be better and truer served by this procedure:

The ophthalmic tuberculin test for tuberculosis is destined to meet a long felt want. Its greatest field of usefulness will be in the early obscure cases of tuberculosis when the internist and pathologist are unable to make so early a diagnosis. It will enable the clinician to outline a plan of treatment early in the disease with the corresponding benefits of early treatment. Most observers are of the opinion that it is harmless and that the effects quickly subside. It should not be used however in eyes, which have any existing inflammatory diseases.



Would it not be commendable for the Kansas Medical Society to adopt a resolution requesting the newspapers of the state to refrain from publishing the names of physicians concerned in the treatment of accident cases, surgical operations, etc. This resolution sent to all the newspapers would eliminate largely the notoriety *ad nauseum* given physicians of more or less repute. What can be more disgusting to the ethical medical man than this fake advertising which many times is forced upon him.



This is an era of experimentation. Almost every Journal of Medicine and Surgery contain long scientific articles exploiting theories, new in name, but old in fact. As far in the past as pathology has been taught, the theory of phagocytosis has been studied. That, in the presence of disease, there is a continual conflict going on between the specific bacteria and the leucocytes may be demonstrated, and has long since been illustrated in malaria, where the plasmodium invades the corpuscle, and the proper remedy retards and checks its destructive work. We designated this as the process of raising the physiological resisting power within the body against the pathological tendency. We give antidotal treatment which destroyed the plasmodium toxins, and specifics to repair the damage done by them. In other words we were raising the "opsonic index" before the term was invented, but we were not capable of giving scientific explanation as is illustrated in the following article (partly quoted) by Charles Frederick Boldnon, M. D., of New York, in the International Journal of Surgery for March, 1908:

The early work of Nuttall and others on the bactericidal action of normal serum and Pfeiffer's demonstration of the bacteriolysis of cholera and typhoid bacilli by immune sera in the absence of cells, formed the chief basis on which rested the humoral theory, which attributed the protection in such cases to the destructive action of the serum on the microbes. It was found, however, that cases of protection resulting from the use of immune serum occurred



where no such bacteriolytic action could be demonstrated; infection with plague or streptococcus may be mentioned as examples. It is now pretty generally accepted that immunity in these cases is due largely to the phagocytic action of the leucocytes. As far back as 1858 Haeckel had observed that particles of indigo injected into the veins of certain molluscs could shortly afterward be found in the blood cells of the animal. However, the significance of this and other observations was not appreciated until Metchnikoff, in 1883, called attention to their bearing on infection and immunity.

The outcome of his investigations was the establishment of the well-known doctrine of phagocytosis, the principle of which is that the wandering cells of the animal organism, the leucocytes, possess the property of taking up, rendering inert, and digesting micro-organisms which they may encounter in the tissues. Metchnikoff believes that susceptibility to or immunity from infection is essentially a matter between the invading bacteria on the one hand and the leucocytes on the other. He realizes that the serum constituents play an important role, but this role consists in their stimulating the leucocyte to take up the bacteria.

Thus, if a highly virulent organism is injected into a susceptible animal, the leucocytes appear to be repelled, and to be unable to deal with the microbe which multiply and causes the death of the animal. If, however, the suitable immune serum is injected into the animal before inoculation, the phagocytes attack and devour the invading micro-organisms. Admitting that the phagocytic plays an important part in certain infections the question must still be considered whether the immune serum has acted on the injected microbes or on the phagocytes. Metchnikoff, we have seen, takes the latter view.

In 1903, A. E. Wright called attention to certain substances present in serum which acted on bacteria and rendered them more easily taken up by the phagocytic cells. He called this substance opsonin, and showed that it is present in normal as well as immune sera. By means of absorption tests modeled after those of Ehrlich and Morgenroth, he showed that the opsonin has a specific affinity for the bacteria and none for the leucocytes. The opsonins for staphylococcus prepare only staphylococci for the leucocytes, those for tubercle bacilli only these bacteria, etc. As a result of his observations Wright supposes that the phagocytes play only a passive role, which depends on the preliminary action of the opsonin.

Bacteriotropic substances. Independently of Wright, though somewhat later, Neufeld and Rimpau, of Berlin, published experiments on the phagocytic effect of immune sera. They also found that in these sera there exists a substance which has no direct action on the phagocytes, but which can fix itself on the corresponding bacteria and so modify these that they are more readily devoured by the phagocytes. They call this constituent a "bacteriotropic substance." There is little doubt that this bacteriotropic substance and Wright's opsonin are identical. Certain differences in the effect of heat are probably to be explained by the differences in the quantities of these sensitizing substances in normal and immune sera.

Opsonins distinct antibodies. It was natural to question whether these "opsonins" were really distinct from the other antibodies, or whether they were perhaps identical with the immune body (or substance sensibilatrice). In a series of papers on this subject Hektoen shows that the former is the case—opsonins are distinct substances. This is not only indicated by the results of absorption tests but by the fact that, by immunization, a serum can in certain cases be obtained which is opsonic but not lytic, or, in other cases, one which is lytic but not opsonic. Similar experiments have differentiated opsonins from agglutinins.

Structure of opsonins. Opsonins, like agglutinins and precipitins, appear to possess two groups opsoniferous and haptophore. On heating an opsonic serum the former group is destroyed, but the haptophore group remain intact as can be seen from suitable combining experiments. There is still considerable difference of opinion as to the degree of heat necessary to inactivate the opsonins. Once the opsoniferous group has been destroyed it is impossible to restore the opsonic action by the addition of a complementing substance.

Hence the opsonins are to be regarded as receptors of the second order and similar in structure to the agglutinins and precipitins.

The opsonic index. In the study of these opsonins Wright developed the



idea that they were highly important in combating a number of bacterial infections, such as staphylococcus and tubercle. His observation showed that inoculations of the corresponding bacteria produced marked changes in the opsonic contents of the infected individual, and that it was possible to estimate accurately the immunizing effect of such inoculations.

**Technic.** Wright's technic of measuring the opsonic power is a slight modification of the Leishman method and is as follows: An emulsion of fresh human leucocytes made by dropping twenty drops of blood from a finger prick in 20 c. c. normal salt solution containing one per cent. sodium citrate. The mixture is centrifuged, the supernatant clear fluid removed, and the upper layers of the sedimented blood cells transferred by means of a fine pipette to 10 c. c. normal salt solution. After centrifuging this second mixture the supernatant fluid is pipetted off and the remaining suspension used for the opsonic tests. Such a "leucocyte emulsion" of course, contains an enormous number of red blood cells: the proportion of leucocytes, however, is greater than in the original blood.

One volume of this emulsion is mixed with one volume of the bacterial suspension to be tested and with one volume of the serum. This is best accomplished by means of a pipette whose end has been drawn out into a capillary tube several inches in length. With a mark made about three-quarters of an inch from the end it is easy to suck up one such volume of each of the fluids, allowing a small air bubble to intervene between each volume.

All three are now expelled on a slide and thoroughly mixed by drawing back and forth into the pipette. The mixture is sucked into the pipette, the end sealed and the whole put into the incubator at 37 degrees C. The identical test is made using a normal serum in place of the serum to be tested. Both tubes are allowed to incubate fifteen minutes and then examined by means of smear preparations on slides and spread and stained in the usual way. The degree of phagocytosis is then determined in each by counting a consecutive series of fifty leucocytes and finding the average number of bacteria ingested per leucocyte. This number for the serum to be tested is divided by the number obtained with the normal serum, and the result regarded as the opsonic index of the serum in question. The presence of a high opsonic index Wright regards as indicative of increased resistance. He further states that the fluctuation of the opsonic index in normal healthy individuals is not more than from .8 to 1.2, and that an index below .8 is therefore almost diagnostic of the presence of an infection with the organism tested.

Application of opsonic measurements. At the present time Wright has correlated all his observations and built up a system of treating bacterial infections by means of active immunization controlled by opsonic measurements.

The principles underlying his method may be briefly summarized as follows:

In localized bacterial infections the infected body absorbs but small amounts of bacterial substances or antigens. In consequence of this, the amount of active immunity developed is but slight. Localized infections therefore tend to run a chronic course. The logical method of affecting a cure in these cases is to actively immunize the body with the invading organism. In a number of infections, notably those of staphylococcus, streptococcus, and tubercle, the degree of immunity is measured accurately by the opsonic index. Following an inoculation with the infecting bacteria (dead cultures in salt solution) there is first a drop in the opsonic index, the "negative phase," then, depending on the size of the dose and the reacting power of the individual, there comes a rise of the index, the "positive phase," or a continuation of the negative phase. The former is obtained with proper dosage; the latter with doses too large or too small. In estimating the size of dose given Wright counts the number of bacteria per cubic centimetre of emulsion injected. Thus in the case of localized staphylococcus infections the doses for adults human range from 100 million to 500 million bacteria. In the case of streptococcus the doses are smaller, averaging about 50 to 100 million. The bacterial suspensions are heated to 60 degrees C. for twenty minutes, 0.5 per cent. carbolic acid is added, and tests are made to insure sterility. The time for inoculation is governed by the opsonic index. If the first inoculation has been properly gauged there is a brief negative phase, followed by a positive phase of some days' duration. As this positive phase gradually drops, one gives another inoculation and watches the effect on the opsonic index. If the index drops

markedly and rises but little, the dose has been too large. Or, if the negative phase is slight, and the positive phase slight and transitory, the dose has been too small. With proper dosage the negative phases are small and the opsonic index is kept fairly well above normal. Hand in hand with this goes on improvement in the clinical symptoms.

Wright and his pupils have published accounts of a large number of cases successfully treated according to this method. The results are reported as especially good in cases of severe acne, multiple boils, lupus, tubercular glands, and bone tuberculosis.

In judging the value of Wright's method we must bear clearly in mind that the essential feature of it is the control by opsonic measurements; treatment of bacterial infections by the inoculation of dead cultures has long been known.

The results obtained by most workers in this country fail to bear out Wright's claims for the method. Thus the author finds that the variation in the opsonic indices of several normal persons is often considerable; that opsonic counts based on fifty leucocytes may occasionally vary by more than 50 per cent., and that it is therefore necessary to count from 150 to 200 leucocytes for each test; that duplicate, triplicate and more tests made of the same serum at the same time and under identical conditions so far as one can tell, frequently give widely divergent results; that the opsonic index and the clinical course of the disease do not always run parallel. Cases may do very well and have the index remain low; other cases may do poorly with an increased opsonic index. It is to be noted, furthermore, that some of these variations in results are unavoidable, at least with the present technic.

In keeping with all other writings upon this subject up to the present time, there is a noticeable tendency to ignore the time-tried treatment of disease which indeed has accomplished the opsonic effect, known only by the name of phagocytosis. There is also exhibited a decided lack of confidence in the efficacy of the serum or vaccine treatment, the newness of the procedure being made the excuse therefor.

An occasional article reaching the laity certainly compels that individual to assume that the experimental stage of therapeutics has just begun.

All of the isms, Christian Science among them, have been augmented if not engendered by this prevalent spirit of complete reform in therapy; the transition from the simple to the complex.

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## CLINICAL NOTES

**Ether Applications in Threatened Suppuration**—Marcille (*La Tribune medicale*), in cases of adenophlegmon and suppurative parotiditis (mercurial) has applied, with success, compresses of gauze moistened ether, which are covered with a piece of oiled silk, and held in place with a roller bandage. From time to time the corner is lifted and a little more ether poured on the compress.



**An Easy method of overcoming the Habit of Smoking**—Kolo-meitzer (*Bulletin medical*, 1907) states that if the mouth be rinsed

with a solution of silver nitrate (one fourth of one per cent) strength, it will overcome the desire for tobacco, because after this is done the smoke causes a gustatory sensation, which is most repugnant, and which removes, for a long time, all desire to smoke.



**"Bone Cases"** should not be dressed too often after operation. The fine granulations which form are liable to be pulled off with the removal of the packing.—*Amer. Jour. Surgery.*



**In Cases of Fracture of the Skull.**—One should wait for focal symptoms before operation, as a linear fracture without depression is often not followed by serious results. On the other hand no time should be lost in raising a depressed piece of bone or exploring the skull for hemorrhage when any focal symptoms present itself.—*Amer. Jour. Surgery.*



**For Chronic Rheumatism.**—Grassett prescribes (*Journal de medecine de Paris*, July 28, 1907):

R Chloride of gold and sodium,.....0.10 grammes  
Distilled Water,.....300.0 grammes

M. Take a tablespoonsful of this solution with each meal for fifteen or twenty days each month.



**Blindness Following the Injection of Protargol in Lacrimal Sac**—F. Park Lewis, Buffalo, N. Y., reports a case (*ophthalmic Record*, Dec., 1907), occurring in his practice. The patient a woman of 50, having flabby tissues and not a high degree of physical resistance, had suffered for some years from dacryocystitis, with a fistulous opening following an abscess. The sac was washed out with a 25 per cent solution of protargol about 1C. C. being used. No reaction followed and the second day another similar treatment was given. Great reaction followed in a few hours with total blindness in affected eye. Orbital cellulitis and optic neuritis developed the latter ending in atrophy. This condition was brought about by the percolation of the protargol into the surrounding tissues through the ruptured sac intensifying the already existing cellulites and involving the optic nerve, either by extension of the inflammation, or by constriction from pressure and in spite of energetic treatment all vision in affected eye was lost. The case which is an unusual one is reported for the purpose of illustrating the possible danger of strong or irritating injections in a sac in which a rupture allows



a possible involvement of orbital tissues and the necessity of exercising extraordinary care under such circumstances.



**Hyposulphites in Dermatology.**—Hyposulphites especially the sodium hypsulphite, is an invaluable remedy in parasitic disease of the nail substance, in form of a solution about half an ounce of the salt to a pint of tepid water; the effected nail to be immersed therein twice daily, for ten to fifteen minutes.—N. E. Aronstam, in Central States Medical Monitor.



**Treatment of Chancroidal Bubo**—Pressure exerted over a chancroidal bubo by means of a pad of absorbent cotton and a snug spica bandage will at times abort the suppurating process and allow the infected gland to go on to restitution. Simultaneously, however, the ulcer must be kept scrupulously clean and free from all detritus. If absorption is not established within three days, the gland must be incised, curetted and drained.—N. E. Aronstam, in Central States Medical Monitor.



**Septal Deviations.**—H. P. Mosher, in the Laryngoscope, state that there are two great causes of deviations of the septum trauma and asymmetry of growth. Of late, he declares, trauma has been held to play only a minor part; the tendency has been to consider unequal development of the two halves of the head the chief cause.

This is true in some cases, but more often the inequality of growth is confined to the bones forming the hard palate, namely, the superior maxillæ, the palate bones and the premaxillæ. Mosher declares that the irregular and delayed irruption of teeth especially the incisors, is responsible for this asymmetry in a large number of cases.



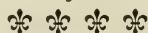
**Aneurism in Celiac Axis Superposed on Aneurism of Aorta.**—G. Baccelli based this diagnosis—which was confirmed in every point by autopsy—on the facts that the patient was a syphilitic and hard drinker, who had had symptoms, previously, suggesting angina of the abdominal aorta, what Baccelli calls "angina abdominalis," similar to angina pectoris. Both ventricles were enlarged, the right less than the left. The stomach was unusually low and the tumor corresponding to the assumed aneurism in the celiac artery rested on the lesser curvature, while no trace could be found of the trunk of the celiac artery. The aneurism in the celiac artery partially rested also on a much older aneurism in the abdominal



aorta; the patient succumbed to a rupture between them. Baccelli's report was published in the Policlínico.—*Jour. A. M. A.*



**Curability of Diffuse Septic Meningitis of Otitic Origin.**—P. Laurens recently reported a case of otitic meningitis due to enterococci. The germs persisted in the cerebrospinal fluid after all the symptoms had subsided. The patient recovered after a spinal injection of a silver salt. In the discussion of the case at the Medical Society of the Hospitals, at Paris, Lermoyez urged routine bacteriologic examination of the cerebrospinal fluid in every case of suspicious acute meningitis. If polynuclears are found showing evidences of destructive action, the meningitis should be regarded as septic, and without loss of time a disinfectant should be injected into the arachnoid sac to sterilize the meninges before irremediable lesions have been induced. The meninges should also be drained by daily lumbar puncture. The subdural injection of the silver salt or other disinfectant acts on the meninges much more rapidly and intensely than in intravenous injection.



**Metabolism in Gout.**—T. Brugsch and A. Schittenhelm sum up the final results of their extensive researches on gout (*Zeitschrift f. ex. Path. u. Ther.*, vol. iv, p. 557), as follows: The gouty individual shows an anomaly of the metabolism of nuclein. This consist in:

1. An increase in the amount of endogenous uric acid in the blood.
2. A diminuation in most cases below normal in the amount of uric acid in the urine.
3. The metabolism of exogenous uric acid is deranged. The excretion of uric acid is diminished and delayed with relative increase of excretion of the purin bases. These derangements are not to be referred to imperfect renal function, but to a disturbance of the whole metabolism of the purins which is to be characterized as a diminution of the formation of both endogenous and exogenous uric acid combined with diminished destruction of uric acid. Finally the authors show that by sparing the powers of the system for forming and destroying uric acid these powers may, as in the similar case of diabetes, be favored and increased. These investigations show the fallacy of all those theories of gout which make derangement of the function of the kidneys a cause of gout.

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## NEWS NOTES

The American Proctologic Society will hold its annual meeting at Chicago, in June, 1908.

Dr. F. J. Wakeman, of Kansas City, Kansas, a specialist on the eye and ear, died on March 30, 1908, of pulmonary tuberculosis.



The State Board of Medical Examination and Registration will hold its next meeting at the High School Building, in Kansas City, Kansas, June 11th, 1908.



Dr. A. W. Meyer, of the University of Minnesota and formerly of John Hopkins has accepted the professorship of Anatomy in Northwestern University Medical School.



Dr. A. N. Richards, of the College of Physicians and Surgeons of New York City, has been appointed Professor of Pharmacology and Surgeons in Northwestern University Medical School.



Dr. John B. Murphy has resigned as Professor of Surgery and co-head of the Department in Rush Medical College and has accepted the Professorship of Surgery and head of the department in Northwestern University Medical School and position of attending surgeon at Mercy Hospital.



The thirty-fourth annual meeting of the Mississippi Valley Medical Association will be held in Louisville, Ky., October 13, 14, 15, 1908, under the presidency of Dr. Arthur R. Elliott, of Chicago. The American Medical Association holds its annual meeting at Chicago, June 2,-5th. There should be a good attendance from this State on account of the close proximity of the meeting place and the transportation facilities.



Announcement has just been made of the selection of the orators for the coming meeting, by the President. The address in Medicine will be delivered by Dr. George Dock, Professor of Medicine in the University of Michigan, Ann Arbor; and the address in Surgery by Dr. Arthur Dean Bevan, Professor of Surgery in Rush Medical College, Chicago. The mere mention of these names is enough of a warrant that this feature of the program will be in every way firstclass.

The Association of Medical Editors of America will hold a convention at Chicago, commencing June 1st.



**Correction**—In the April issue of the Journal appeared the following: "For your information we would state that Neuro Lecithin has been approved by the Council of Pharmacy and Chemistry." The balance of the article had no connection whatever with the above statement.—Editor.



The following articles have been added to the list of New and Non-Official Remedies approved by the Council on Pharmacy and Chemistry:

Aromatic Cordial, P-M. Co. (Pittman-Myers Co.)

Oleum-Ricini Dulcis. P-M. Co.

Atoxyl Hypodermic Tablets 1-3 grain, (Koechl & Co.)

Novocaine Hypodermic Tablets, 1-3 grain, (Koechl & Co.)



It has been decided to combine the annual commencement dinner tendered to the graduating class and the alumni, by the faculty of Northwestern University Medical School, with the alumni banquet to be held during the meeting of the American Medical Association. This dinner will be held at the Illinois Athletic Club on Michigan Avenue on the evening of June 2. It is hoped that all graduates of the Northwestern University Medical School will be present at the meeting of the Association and will attend this dinner.



The Kansas City Veterinary College, located in Kansas City, Mo., is making such improvements in their equipment which will make it second to none of the like institutions of the country. With in the past year one new building for laboratory purposes has been erected and another building is in contemplation. A truly scientific course of instruction is given in this college. The faculty numbers twenty professors. There were 450 students enrolled during the past year.



#### NEW MEDICAL SOCIETY.

A Medical Society was organized in Liberal Tuesday, April 7, composed of physicians from Meade, Stevens, Seward counties, Kansas. Physicians from Beaver County, Oklahoma, were also present. The new society is to designate the Tri-County Medical Society of Kansas, and meetings are to be held on the first Tuesday of every month at accessible points determined by a vote of the

society. The next meeting is to be held in Liberal. Temporary officers were elected as follows: Dr. Roscoe Nichols, President, and Dr. T. L. Higginbotham, secretary. The physicians of this part of the state realize that an active Medical Society is an essential to the up-to-date practice of medicine here as elsewhere and a hopeful atmosphere of energy and enthusiasm prevailed the first meeting.

T. L. HIGGINBOTHAM, M. D., Secy. protem.



The McGill University Alumni will hold a banquet at the Great Northern Hotel, Tuesday evening, June 2nd, 1908, during the meeting of the American Medical Association in Chicago. The committee in charge of the banquet is as follows: D. R. MacMartin, M. D., J. Brown Loring, M. D., and Andrew Stewart, M. D.

ANDREW STEWART, M. D.

Member of A. M. A. Alumni Committee.

Special headquarters will be provided at the Auditorium Hotel for alumni of the Medical College of Ohio. There will be a reunion of the alumni of this College Tuesday evening, June 2, 1908, at the Bismarck Hotel, 180 E. Randolph Street, where there will be a smoker and entertainment. Further information can be obtained by addressing Dr. William H. Wilder, 103 State Street, Chicago, Chairman of the resident alumni.

The local alumni of the University of Maryland will give a smoker and buffet luncheon, during the meeting of the American Medical Association in Chicago, on the evening of June 2nd, 1908, in the Victoria Hotel, northwest corner of Michigan Avenue and Van Buren Street, to which their own and all other visiting alumni are cordially invited.

L. D. GORGAS.

Member of the A. M. A. Alumni Committee.

There will be a dinner and reunion of the Harvard Medical Alumni at the Great Northern Hotel during the meeting of the American Medical Association, Tuesday, June 2, 1908, at 6 P. M., to which every Harvard man then in Chicago is earnestly bidden to come. Please notify the undersigned as soon as possible so that proper provision may be made. A register of Harvard men will be kept at the Alumni Headquarters in the Auditorium, where information, etc., may be obtained.

HENRY F. LEWIS,

42 Madison St., Chicago.

Member of A. M. A. Alumni Com.

The members of the Alumni Association of the Western Pennsylvania Medical College (Medical Department of the Western Univ. of Pa.) attending the meeting of the American Medical Association in Chicago June 2-5, 1908, will hold a reunion and Dutch Luncheon at the Tom Jones Cafe, 175 Jackson Boulevard, Tuesday evening, June 2nd, at 7 P. M. All members take notice that this is the only invitation they will receive. Everyone is expected, so do not fail to come and meet your college classmates and friends. Members are requested to register at the General Alumni Headquarters at the Auditorium Hotel, corner Michigan Avenue and Congress Street, as soon as possible after their arrival in the city.

DR. H. E. ALMES.

Member of A. M. A. Alumni Committee.



The Phillips County Medical Society was reorganized March 18, 1908, and the permanent officers are as follows: President, Wm. G. LeRew, Marvin, Kans.; Vice-President, W. W. Scott, Long Island, Kans.; Secretary, D. D. Haggard, Phillipsburg, Kans.; Treasurer, R. M. Tinney, Kirwin, Kans.; Censors: H. D. Brothers, Agra, Kans., 1 year; G. A. Van Diest, Prairie View, Kans., 3 years; A. G. Davis, Logan, Kans., 2 years. Committee on Health and Public Legislation: J. L. Shewmaker, Phillipsburg, Kans.; John Jeninx, Prairie View, Kans.; F. E. Richmond, Logan, Kans.

D. D. HAGGARD, Secretary.

To the Alumni of the Kentucky School of Medicine:—During the meeting of the American Medical Association there will be a reunion and banquet of the alumni of our college at the Auditorium Hotel, June 2, 1908, at 6:30 P. M. The members of the faculty will be present, and hope to meet the alumni from the entire country. An attractive musical program is being arranged, and there will be addresses from the alumni and members of the faculty. Address all communications to Dr. J. R. Pennington, Secretary of the Alumni Committee, appointed by the American Medical Association for the Kentucky School of Medicine, 103 State Street, Chicago.

On the evening of June 2nd, 1908, an alumnae dinner and entertainment in honor of the visiting medical women of the American Medical Association will be given at the Mid-day Club, First National Bank Building, corner of Dearborn and Monroe Streets, by the Woman's Alumnae Committee, the Medical Woman's Club of Chicago, and the Woman's State Medical Society. The medical women of Illinois hope that a large representation of women physicians of the A. M. A. will attend this year's session, as they are making a special feature of the Women's Alumnae Reunion. At this dinner several important subjects will be discussed which are of special interest to all women in the profession.

DR. KATHARINE BRAINERD RICH

Member of A. M. A. Alumni Committee.

The County Medical Society met Tuesday evening, March 24, 1908, with the President, Dr. C. R. Silverthorne, at McFarland, with the following doctors present: Drs. Beverly, Johnson, and Meyer, of Alma; Dr. Menard, of Paxico; Drs. Yates and Kemper, of Maple Hill; and Drs. Robler and Silverthorne, of McFarland. Dr. McGuire, an eminent Topeka physician, was present and delivered a very able discourse on medical science in reference to the finding and treatment of diseases. Dr. McGuire is a recognized authority on matters pertaining to the profession and his counsel and co-operation is earnestly sought by his co-workers. The object of the Society in meeting on stated occasions for the exchanging of experiences in reference to their profession is a most commendable one and all reverts to the well being and good of the sick and afflicted. There will probably never be a single meeting of the Society at which some member does not receive an idea or obtain a help that will be of much good in his work among his patients. The organization of this Society is the best thing the doctors of the County have done in many years. At the close of the discussions the guests were invited by Mrs. Silverthorne to gather around the well appointed dining table and were served with a delicious six course supper. The table decorations were large red carnations and ferns. Covers were laid for Doctors McGuire, Beverly, Kemper, Menard, Robler, Johnson, Meyer, Yates, Mrs. Beverly, Mr. and Mrs. H. C. Sticher, and Dr. and Mrs. Silverthorne.

At the short business session held after the supper an unanimous vote of thanks was accorded the Doctor and his good wife for their cordial hospitality.—Alma Signal.

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### PRESIDENT'S ADDRESS.

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#### The Kansas Medical Society: Its Mission, Its Needs and Its Purposes.

Delivered before the Forty-Second Annual Meeting of the Kansas State Medical Society, held at Iola, May 6-8, 1908.

By J. E. SAWTELL, M. D., Kansas City, Kansas.

Each year as the time for the annual session of the Kansas Medical Society draws near, every member should be thrilled anew with interest and high purpose. A medical society should mean much besides the aggrandizement of a few of its members. It should be potent for the betterment of the profession throughout the state, and a distinct force in the advancement of public welfare; and now that the time for our Forty-second Session is at hand, it should be an occasion of much interest to those members of the profession who have at heart the progress of Medical Science.

For the first time in the history of this Society we find ourselves environed with the hospitality of the energetic and thriving city of Iola; but in justice let it be said that our coming together at this place is due not so much to the considerate judgment of the Council, entrusted with the duty of selecting a location, as to the desire of the local profession, evidenced by their cordial and generous invitation.

The experience of this Society in meeting in the smaller cities which are remote from the larger railroad centers has not been encouraging so far as concerned the numbers in attendance; and unless this meeting proves an exception to the past, it would seem inadvisable to again hazard its interests in this manner.

I trust that the inspiration which has brought forth this assemblage from the various parts of the state is in obedience to the declared purposes of this Society, which are in part: "To extend medi-

cal knowledge and advance medical science; to elevate the standard of medical education and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians, to guard and foster the material interests of its members and to protect them against imposition; and to enlighten and direct public opinion in regard to the great problem of State Medicine so that the profession shall become more capable and honorable within itself and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life."

If such shall have been the inspiring motive of our coming together at this time, then our labors will not have been in vain, though our attendance may not be so great as at other times.

The year just closed has not been one of such growth as was the preceding. This is due mainly to the fact that nearly all of the counties had been organized, and to the further reason that the building up of the county organizations has been left largely to the societies themselves. Results would seem to indicate a feeling on the part of far too many of our members that obedience to the Principles of Medical Ethics and the payment of annual dues constitute the sum of their obligations to this Society.

These are merely involuntary evidences of interest, since a pledge to the former is a requisite of membership, and our efficient Treasurers always insists upon the latter.

There are over twenty-five hundred physicians in the State of Kansas, and a little more than fifty per cent of these belong to the State Society. This is a very creditable showing as compared with other States, but not what it should be for Kansas. The favorable comparison should not cause us to fall back upon our laurels, however, but should, on the other hand, be an additional incentive to effort. When we recall to mind the real object of medical organization, the fact is at once apparent that of all bodies the County Society is of the greatest importance, as it can be made most useful both to the public and the profession. In order that organization may be complete, and have the widest scope of usefulness, State and National Societies are essential; but since they derive their power and influence from the local societies, these in return should receive support and encouragement from the former.

At the meeting of the Council in December it was the consensus of opinion that the Councilor Districts were too large, and that the State should be re-districted and a larger number of districts formed, with a smaller number of counties in each, as is the case in many other states, where the best results have been accom-

plished. There seems, also, to be a growing desire on the part of many of our members to have the District Branch Societies restored, as was formerly the case; but should this be done according to our former plan it would reduce, rather than increase, the number of Councillors. I am of the opinion that a reorganization of the District Societies, without making them organic bodies of the State Society, and a suitable increase in the number of Councillors, would be of material benefit to this Society.

The present trend of modern medical thought is along the line of preventive, rather than curative medicine, and the time is well at hand when our Society should exert a more active influence in this direction. It is regrettable that the medical profession of Kansas, as a whole, have been rather an unimportant factor in securing sanitary legislation; and whatever has been accomplished in this direction has been due to the energy of a few.

The splendid work done so efficiently by our State Board of Health in helping to secure the enactment of much needed sanitary laws, and its assistance in the enforcement of the same, as well as its educational influence on the public, is worthy of the highest commendation.

If the best results are to be obtained, the people must be educated to a point where they can better understand the broad, humanitarian principles of preventive medicine and sanitary science.

This can not be brought about by individuals. It can only be done successfully through the influence of an authoritative organization like this Society, in a manner that is becoming to the dignity of our profession.

Let the public understand that one of the main purposes of our organization is for public advantage, and that preventive medicine is the climax of professional unselfishness, and not an empty pretense and a dead letter in our constitution. One of the high aims of medical organization is the moulding of public and professional opinion in such a manner as will result in the mutual welfare of all concerned. That the public should be slow to credit the sincerity of our motives in teaching the doctrine of preventive medicine is no more to be wondered at than that the pagan worshippers of old were slow to accept the teachings of the lowly Nazarene.

Until recently the teaching of the people has been mainly at the hands of quacks, charlatans and ignorant pretenders through the advertising columns of newspapers; and I regret to state that religious, as well as secular publications, have lent their aid.

Therefore, whatever fault we may be inclined to find with the public in this respect should be transferred to our own account, and



charged to neglect of duty. A comparison of the arguments used in favor of the National Pure Food and Drug Law, recently enacted by Congress, with those used in favor of the first Pure Food Bill passed by that body some years ago, furnishes most satisfactory evidence of the effectiveness of educational work as it has been done by and through the National Legislative Council of the American Medical Association. The first Pure Food Law passed by Congress was that prohibiting the adulteration of lard with cotton-seed oil, and the arguments mainly used in favoring the passage of the bill were based upon the protection of the American hog.

The next was the Oleomargarine Bill, which was argued from a commercial standpoint alone and passed as a commercial measure. In neither instance do the arguments show any reference to the protection of the people against the adulteration of food. Let the people first be rightly informed, then with a united effort on the part of the medical profession there will be no delay in securing the enactment of those laws upon which the comfort, the health and the lives of the community so largely depend.

A Vital Statistics Registration Law is one of the great needs of this state. A year ago the matter was brought before this Society and a Committee appointed to co-operate with the State Board of Health. All are so familiar with the need of such a law that any argument in its favor is superfluous.

Another matter of vital importance to the people of Kansas is the tuberculosis problem. If our State is to keep in line with the forward movement of many other states in the prevention and treatment of this disease, an institution should be erected and maintained for our tubercular poor. Separate pavilions should also be maintained in each of our State Institutions; and I understand that it is the intention of the Board of Control, as well as the State Board of Health, to recommend this in their reports. I earnestly hope that every member of this Society will give his individual support to these measures, and that our committee on Public Policy and Legislation shall be instructed to co-operate with these Boards.

Too often there is, in the life of the busy physician, a well marked tendency to overlook or underestimate the importance of various duties to his profession in general, and in his enthusiasm over his individual work, to become lukewarm regarding matters of broader scope where combined effort, intelligently directed, can accomplish so much.

While the erection of Sanitoriums and separate pavilions would be a long forward step in the solution of this problem it is,

not all that should be done, nor is it certain that this is the best and most efficient work that might be done. An educational campaign, such as is being waged in other sections of the country, aided by a tuberculosis exhibit, would be productive of more extensive results than the institutional method, for at best there could not be to exceed two hundred cases reached by the Sanatorium method annually, while through the educational process several hundred thousand people could be reached, and the knowledge of prevention extended to those who are yet uninfected which is vastly better than making the effort to cure after infection.

There are other matters, of equal importance, for which legislation should be sought, such as the exclusion of the tuberculous dairy cow and the inspection of all animals slaughtered for food in the State. When we consider the claim that has been made by some that from five to sixty-five per cent of the herds of this country are tuberculous, the real importance of such a law is at once comprehended.

One of the specific purposes of our society is the elevation of the standard of medical education. This subject has received much valuable consideration since reorganization, and the concentrated action on the part of our affiliated organizations. The fact has long been recognized that the greatest deficiency in our system of medical education in America is the low standard of preliminary requirements. Whatever apologies may be offered in extenuation of such past neglect, there exists no shadow of any justifiable reason why a fair standard of preliminary training should not be required, at the present time.

The Council on Medical Education, a body created by the National Association some three years ago, merits the highest praise for its fearless work in disclosing the comparative status of all medical schools in this country. The breadth and importance of the work can be better understood from the following extract, taken from the report of the council at the last annual session of the American Medical Association.:

"There are, in this country, 160 Medical Schools—about as many as there are in Great Britain, Germany, France and Austria combined. The schools in this country represent all grades, from the the highest—as high, probably, as those of any country in the world, to the very lowest, a number being but little better than diploma mills. On this inspection schools have been found that are absolutely worthless, being without any equipment for laboratory teaching, without any dispensaries, without any hospital facil-

ities; some of which are no better equipped to teach medicine than is a Turkish bath establishment or a barbershop. Many of them are little more than quiz classes, in which men are drilled for the purpose of passing State Board examinations. Some of the schools inspected are conducted by men in good standing in the profession, but about in the same manner in which schools were conducted twenty-five or thirty years ago; simply didactic lectures and quiz classes, without proper laboratory or clinical facilities; and some of these men apparently do not realize the bad work they are doing in the light of modern medicine."

This being a true report of the conditions of medical education in this country, it becomes the duty of this Society to lend its support and encouragement to the State Board of Medical Registration and Examination in its endeavor to maintain a standard of requirements that will prevent applicants, who have had their medical training in schools not recognized by this Council, from receiving licenses to practice medicine in this state. Such action would be in harmony with the spirit of the Medical Practice Act of this State which is, most of all, for the protection of the people.

It would only be justice to the profession, as well as to the fully recognized medical schools of this state which are maintaining both a splendid degree of entrance requirements and a high standard of medical education.

In a communication received from the Council on Medical Education an earnest desire was expressed that the Kansas Medical Society might send a representative to attend the Fourth Annual Conference which was held in Chicago on April 13th. As questions of extreme moment to the cause of medical education were to be discussed at the conference, it seemed important that this Society should be represented; so I appointed Dr. F. M. Daily of Beloit, who will submit a report of the transactions of this Council, during the present session.

At the recent meeting of the American Medical Association in Atlantic City, an organization of the Secretaries of State Societies and Editors of State Journals was formed. A common advertising agent in New York has been secured for all state journals, and it is the intention to secure others in the central and western states.

A committee of this organization was appointed to confer with the various state associations, and if possible get them to defray the expense incurred by their Secretaries and Editors in the attendance of a full meeting to be held at the Auditorium Hotel Chicago Monday evening, June first, 1908. A communication to this effect has been received from the secretary of this committee;

and as many matters of the greatest import to the state Societies are to be considered, it is obvious that the benefits to be derived will make it well worth the amount of the necessary expense, and I would recommend that this Society comply with the request.

The Journal of the Kansas Medical Society, through the efforts of its efficient management, has been a most potent factor in building up and maintaining the stability of our Society. No single factor has a more stimulating effect in fostering medical organization and a true spirit of fraternity, devoted wholly as it is to the interests of the medical profession of the state. Items of local interest, personal news, legislative matters of medical importance and the published proceedings of both the legislative and scientific bodies of this Society, all have a tendency to awaken interest and to enlist sympathy and co-operation. The Journal has not, as yet, become self sustaining: but through the new arrangements recently made by the Council for its management and publication, it is confidently hoped that this result can be achieved within a reasonable time.

Much has been said of late to the effect that the physician of today does not occupy the same position of influence in the community that he occupied a few decades ago, and that he has lost dignity in the estimation of the laity. It has also been claimed that even "Modern medicine, with all its advantages, improvements and enlarged resources" stands before the public shorn, apparently, of much of that dignity and appreciation that was formerly extended to a less developed science. That this is true in some measure can not be denied; but it is doubtless due to the commercial spirit of the age in which we are living. The change in social position is due largely to the changes that have taken place in the people. A half century ago the interests of the country were less diversified, and its wealth less developed and distributed.

Many of the luxurious habits of today were unknown to public and private life. Then education and character were quite universally regarded as the highest measures of worth, and counted for more than wealth; but today the influence of wealth and the commercial activity of the country seem to overshadow and detract attention from the more quiet channels of life in which the physician, from necessity, must have his sphere of activity.

I do not share the pessimistic view that the profession today, as a whole, is unworthy of the high regard and confidence that was once reposed in it by the public. To the contrary, if education, morality, a high type of citizenship and a sacrifice of self in undeviating devotion to duty were accepted as the measure of true



worth, no calling in the land would occupy a more lofty height on the pinnacle of worldly esteem than the medical profession of today. However, there are some among the physicians of today who are not faultless, but whose misguided conduct fails to merit either our indulgence or our approval. It is to be regretted that the tendency on the part of some of the well-meaning members of our profession is to disregard the traditions of the profession and to give themselves over to the commercial spirit of the times which is, alas! too common in many walks of life. I can not refrain from referring to the vicious practice of giving and accepting commissions for cases referred to the consultant or surgeon. This has become a more serious matter for consideration since specialism has grown to be so universal; but I do not believe that the evil exists in this state to the extent that it does in other localities, nor that it is as prevalent as is commonly reported. Personally I can speak for the integrity and good name of the profession, as I have never been approached with an offer that was mercenary in any sense.

The "Principles of Medical Ethics" refers to this matter in these words: "It is derogatory to professional character for physicians to pay or offer to pay commissions to any persons whatsoever who may recommend to them patients requiring general or special treatment, or surgical operation. It is equally derogatory to professional character to solicit or receive such commissions."

Dr. Mayo, in his recent presidential address before the American Medical Association spoke against the pernicious custom in these terms: "The one crying evil, which fortunately is not widespread, is the giving of commissions—in other words, the selling of the confidence which the patient has in the practitioner to some specialist who will divide the fee in return for reference of the case. The one takes money from the patient without his consent and the other, in order to complete the bargain, charges more than he should. This is equally harmful to the one who receives and the one who gives. Such matters can not be kept secret, and I have personal knowledge of men of high attainments and remunerative practice who have been ruined by losing the confidence of their communities through this pernicious traffic. Some attempts have been made to justify it; but the very fact that it is secret shows that both parties are ashamed to have it known, and is an acknowledgment of its moral obliquity."

I can myself refer to more than one case that has recently come to my knowledge where both surgeon and practitioner have lost confidence of the community on account of the fact that this breach of professional integrity gained publicity.

More recently there has been an effort on the part of some to justify this evil under the disguise of a more respectable attire, calling it "division of fees". The Editor of the Journal of the American Medical Association in the issue of October 19th, 1907, deals with this subject in the following conclusive manner: "There can of course, be no ethical objection to the surgeon including the physician's charges in his bill, provided the patient clearly understands that such a division is to take place. To argue that the only way to secure the physician his just dues is for the surgeon to include it in his own fee overshadows all possible claims to honesty in the transaction.

We can hardly refrain, however, from the belief that the difficulty exists mainly in the minds of interested parties who find in the practice of division of fees a means of illicit gain.

"To sum up: First, if the patient knows of the transaction between the surgeon and the attending physician, there is no objection to such a division. If not, it is clearly a dishonest transaction. Second, the giving of commission is dangerous under any circumstances because of the inevitable tendency to bias the physician in his choice of a surgeon in favor of the one from whom the most substantial consideration is likely to be obtained. No other factor ought to enter into the physician's decision than the best interest of his patient. Third, the division of fees, however different theoretically is practically identical in its effects with the giving of a commission."

County societies are already beginning to take cognizance of this evil and to condemn it. Imagine these offenders against ethics, men of ability and influence in the profession, ordinarily taking an active part in medical society affairs, having to sit quietly, conscience stricken, self-convicted, and vote in favor of the condemnation of their own clandestine acts without daring to raise a voice in opposition! Such humiliation of professional dignity and self respect should be sufficient to neutralize the spirit of commercialism in those who have not yet passed beyond the stage where reclamation is possible. As this evil seems to be founded upon secrecy, it is impossible for it long to exist under the searchlight of publicity.

It is a practice that should be condemned by the profession everywhere, and suitable by-laws should be enacted in county societies so that the matter could be dealt with in a proper manner should occasion require. Such action would have a wholesome influence upon the young men just entering our profession, for it is too often the case that these yield to the corrupting influence of older heads, and become parties to this offense. They should be in ev-

ery way imbued with the lofty spirit of our highcalling before commercialism and mercenary tendencies become fixed principles in their lives.

"Lands mortgaged may return, and more esteemed,  
But honesty, once pawned, is ne'er redeemed."

To uphold the honor and dignity of our profession is a well defined duty, both as individuals and as a Society. A proper respect for our own profession, emanating from the members of our profession, will better insure a full measure in return from the public.

In the words of Holmes, "If you do not feel, as you cross the millionaire's threshold, that your art is nobler than his palace, the footman that lets you in is your fitting companion, and not his master."

While the closing year has not been one of unprecedented increase in membership, yet the profession of our state have never been more united and harmonious, and the Kansas Medical society has never wielded a more potential influence for the betterment of affairs pertaining both to the profession and the public, than at the present time. Thus united and striving for a common purpose, filled with earnest desire for a strict observance of the Principles of Medical Ethics, and a more determined effort to make effectual the declarations enunciated in Article II of our constitution, we may confidently look forward to a more glorious future for our profession than hath yet been seen.



## COLITIS.

### Possible Anatomical Causes for; Surgical Treatment of; With Report of Case.

By DR. H. L. SNYDER, Winfield, Kansas.

Read before the Kansas Medical Society, May 7, 1908.

The subject of Colitis is a familiar one in its medical phases, but one which does not often require surgical intervention. I present this paper not entirely because of the case I have treated surgically, but also on account of the opportunity it gave me to study that important organ, the colon, with an opening at each end.

Neither do I propose to take up the medical treatment in detail, but rather to point out those things which were new and of interest to me, hoping that they would be to you also.

A recent work on practice describes four types of colitis, name-

ly acute colitis, mucous colitis, follicular, croupous, nodular or ulcerative colitis, and pseudo-membranous colitis.

Acute colitis is an acute condition, usually follows exposure to cold, is quite severe, with a tendency to rapid recovery under appropriate treatment.

Mucous colitis is essentially a chronic condition, and in temperate climates the most common affection of the colon, dysentery being more prevalent in tropical countries. The development is insidious, and the condition lasts several years, attended by general ill health and marked impairment of nutrition. These patients are nearly always neurasthenics and hypochondriacal.

They suffer from abdominal distress attended with colicky pain. On account of hyperperistalsis of the small bowel, the food is hurried through before it has time to be digested and absorbed.

Taking of food causes within an hour three or four bowel movements of a lenteric character, in which there will be great quantities of mucous in various forms. This mucous is often very thick and resembles a false membrane. Blood is rarely passed, unless due to some local condition in the rectum. Anemia is present if the condition lasts long.

There is marked tenderness over the bowel and the patient thinks she can tell where the mucous comes from, and will tell you she feels better after passing a large amount.

I wish to refer especially to the nervous condition of patients with this trouble; for many of us have been wont to consider them neurasthenics and to pass them by as such.

Fortunately, their symptoms are based on a definite entity, which should be discovered and removed, thereby gaining for you their lasting gratitude.

The third form of colitis is designated as follicular, croupous or nodular colitis. Primarily there is marked swelling of the solitary glands followed by necrosis and ulceration. These not healing, leave chronic ulcers. At times in croupous colitis a true false-membrane forms, which may exfoliate, or extend into deeper structures which slough, leaving ulcers of large size. Many pathogenic bacteria are present in these cases, and because of the ulceration they are chronic.

The fourth form of colitis, pseudo membranous colitis, is characterized by a superficial necrosis, at times diffuse, but more commonly distributed in patches. These necrotic areas slough and leave ulcers, and a chronic condition.

In addition to the above forms of colitis, we must consider the forms described under the head of dysentery, in which we find a



more or less definite bacteriology. Namely that due, to the amoeba coli, to the bacillus of Shiga, to the KlebsLoeffler bacillus and the catarrhal form in which the bacteriology is not definite. This form of colitis is most frequently seen in those who have lived in our island possessions, usually as enlisted soldiers. However it is of interest to know that many cases of cholera infantum are due to the bacillus of Shiga.

The etiology of this condition of colitis is not given much consideration, except to assign some bacterial infection as causative.

I wish to consider the anatomical situation and relation of the colon, and thereby show why such infections occur. The anus opens directly on the skin having an opening for external infection, which by extension reaches the colon. If we will study the colon in situ, beginning at the cecum, we will find it directly back of the abdominal wall, at times not covered by omentum and extending well toward the middle line. The ascending colon in 75% of all cases, is back of the peritoneum with no meso-colon. It lies against the psoas and quadratus lumborum muscles, the right kidney and the liver at the hepatic flexure. Its length is 8 inches and it lessens in size away from the cecum.

The transverse colon is 20 inches in length and loops downward to or below the umbilicus, then up to the left hypochondrium where it in relation with the spleen, leaving an attachment to the insertion of the diaphragm. Necessarily throughout this part of its course the colon lies directly behind the abdominal wall.

The descending colon is 8½ inches in extent, has no mesa-colon and lies from above down on the spleen the diaphragmatic attachments, left kidney, quadratus lumborum, psoas and iliac muscles. This is the smallest part of the colon.

The sigmoid loop or iliac colon is 17 inches long, and in form resembles the Greek letter Omega. Extending from left to right, in many cases reaching the sacrum then bending back from right to left it is attached to the sacrum at about the third segment, continuing then as the second part of the rectum.

The rectum follows the curve of the sacrum downward and forward for 3½ inches to the neck of the bladder; then as the first part of the rectum downward and backward to the external sphincter.

The blood supply of the colon is derived from the inferior mesenteric artery, with branches from the superior mesenteric, and is abundant.

Because of its position the colon is more apt to suffer trauma, either from blows on the abdomen or by muscular action. Being

fixed in part of its course, slows the fecal current, allowing absorption of fluids and renders the fecal masses hardened and dry. In addition, the colon bacillus is always present and ready under favorable conditions to assume a pathologic role. Chronic appendicitis when there is a gradual throwing out of pus into the colon, may cause colitis.

Any one or all these factors may cause inflammation in this part of the bowel, but do not affect the small intestine.

Another common factor is constipation. This requires laxatives or purgative often detrimental. This brings into use that ever present, fountain syringe, than which I believe there is nothing more harmful. If used judiciously and sterilized before use, it may be of benefit to relieve the colon of hardened masses. Often however, it is old, dirty and a menace; because, by its use, with too much water, the colon is over dilated and constipation made worse, sooner or later producing a colitis.

It is generally believed that to reach the cecum two quarts or more of water are required. I demonstrated time after time, while treating a case last summer, that  $8\frac{1}{2}$  ounces of normal salt solution, introduced into the anus with a short anal tip on the syringe, would flow out of a colostomy opening in the cecum. Four ounces of olive oil will do the same.

From these observations, I believe that not only is there great harm done by the use of injections in chronic constipation, but also, in acute inflammation of the appendix it may be rendered gangrenous by too much water pressure.

I wish also to criticise the use of the colon tube, for I believe in most cases, as much can be accomplished by a short anal tip as with the colon tube. No doubt someone will take issue with me here. Did you ever consider the direction your tube must take to reach the colon? Did you ever examine the rectum with the tube in situ? What did you find? Nine times out of ten your tube was coiled up in the rectum. Ordinarily you will insert the tube twelve or fifteen inches. Where does this take you, provided you are fortunate enough to carry the tube into sigmoid flexure.

The rectum is  $5\frac{1}{2}$  inches, the sigmoid 17 inches. Suppose the tube is inserted fifteen inches, it has merely reached the loop of the flexure. The rectum will fill before the water will go on higher up and you have gained nothing over a short anal tip. There is always danger that the tube may puncture the bowel at some weak place.

Another important consideration, particularly in mucous colitis is the peculiar nervous condition of these patients. Whether cause

or effect is a question, possibly both. All of us are familiar with cases in which sudden fright or emotion will cause a movement of the bowels. In colitis this tendency is manifested upon the slightest pretext. Possibly it may account for the hyper-secretion of mucous and hyperperistalsis.

When do these cases require surgical treatment? After having careful dieting, medication and local treatment without relief, then is surgery indicated.

### SURGICAL TREATMENT.

Two procedures have been described and used, colostomy and appendicostomy. Each has advantages. Appendicostomy is more easily performed, gives less discomfort, and the wound can be more easily closed. On the other hand, the appendix is sometimes rudimentary, too small to pass a catheter through. You obtain the advantage of irrigation only and the colon is not put at rest.

Colostomy puts the colon at rest, gives better access for local treatment, but causes more discomfort, yet I think is the better procedure.

Appendicostomy is performed through a gridiron incision, by bringing the appendix out and fastening it in the wound. After adhesions have formed, the end of the appendix is cut off and a catheter inserted and the bowel irrigated.

Colostomy for colitis is done through an incision over the cecum if possible without dividing the muscles, so as to give as much control over the bowel by the muscular support. The cecum is brought into the wound, and attached so that a spur is formed which will divert the fecal current out of the wound, not allowing it to pass down the colon.

The spur may be formed by any one of several methods, each of which have the name of the surgeon describing it; either by passing a glass rod, a piece of gauze or a bridge of skin through a slit in the mesentery, or by suturing the colon, bent at an acute angle, along the mesenteric border on each side. Each method is good. The bowel is sutured fast in the abdominal incision and the wound closed tightly around it, permitting one knuckle of bowel to protrude.

After forty-eight hours this knuckle should be opened longitudinally, for you wish to close it later. A laxative should now be given to thoroughly empty the intestinal tract. The skin should be protected by a generous coating of lanolin, for the fecal matter is very irritating and will cause ulceration.

The colon should be irrigated from below upward, using normal salt solution. This should be done twice daily. If there is

much tenderness in the bowel, the injection of six ounces of olive oil will be found useful.

When should you close the colon? After the colitis is cured. The time cannot be estimated, as it is a question of conditions not time.

When the colitis is cured, the bowel can be closed while still fastened in the abdominal wall; then loosened and restored to the abdomen after the danger of leakage is passed. The abdominal incision is then closed.

Case 1. Woman, age 40, white, married, mother of two children. Applied to me for treatment November, 1906. Family history good, no tuberculosis or malignant disease. Personal history, enjoyed good health until five years before, when she had a ventral fixation of the uterus, with repair of cervix and perineum. Within a year a floating kidney was anchored, following which operation she developed an impaction of the bowels, which was relieved with difficulty. From this time, the colitis was noticeable, gradually getting worse. There was a progressive loss of flesh and weight with constant pain and discomfort. The diet gradually being limited more and more until Nov. 1906, when everything she ate was liquid and strained. Taking this would cause two or three bowel movements, within an hour, with which she passed an immense amount of mucous. Patient was extremely nervous. Lungs normal, heart normal but too rapid, urine normal except an occasional hyaline cast. Mucous passed by the bowel contained no definite bacteria of the group causing dysentery.

Everything feasible in medicinal treatment was tried, with a progressive increase in condition. On August 5, 1907, with Dr. L. A. Jacobus, of Coffeyville, counseling and assisting, we did a colostomy. The appendix was small and not inflamed, and was removed. The colon was opened Aug. 7, 1907, and for two days there was a constant stream of black mucous and fecal matter expelled, often coming in casts five or six inches long and two inches wide. For the next sixty days mucous gradually disappeared; the bile colored the stool normally; the tongue peeled off like a patient recovering from typhoid fever and did not recoat. There was a progressive gain in weight and strength.

The colon was irrigated twice daily with normal salt solution, occasionally using olive oil instead. Internally iron with a digestant was administered. The food comprised a general diet and was well digested. There was some leakage of fecal matter all the time, but the bowels moved twice a day. The stool was soft and partly formed. The wound was left open six weeks after all mucous



had disappeared and was closed in two stages; the first part on Nov 18, 1907, the last two weeks later. The bowels moved the normal way thirty six-hours after closure, without any particular discomfort. Since then and nearly six months have elapsed, there is bowel movement each morning. There is no sign of the old trouble.

The mucous has disappeared entirely.

I am indebted to Dr. L. A. Jacobus of Coffeyville and Dr. C. T. Ralls of Winfield for their assistance in this case.

#### DISCUSSION.

DR. J. G. SHELDON—This paper covers so much ground I shall not attempt to give a complete discussion. I would say this case is an example of the idea that colitis is a pathological condition. Now besides the inflammation inside the colon there are many cases of colitis that are due to conditions outside the bowels. Appendicitis was mentioned and most often when that is the cause of colitis there is a cone shaped appendix, and it can and does produce colitis, and the removal of the appendix is sufficient. We have other inflammatory conditions in the abdomen that involve the colon secondarily, and in this case, it seems to me it would be wise not to drain the colon first, but to operate for these conditions of which colitis is secondary. So before we decide to open the colon it is well to see if there is not some pathological condition within the abdomen that involves the bowels secondarily, and which, if not relieved, will in all probability have a tendency to bring about a recurrence of the colitis. As regards ten oz. of fluid coming from the rectum, the question comes up of reversed peristalsis, which is claimed to be a normal condition. Some say, especially, Blake, that is a normal condition absolutely, and that fluid coming down from the small intestine coming into the large intestine is forced back and distilled into the cecum. If I understand the doctor correctly he gave us the impression that the left colon was fixed and it had no mesentery. If I remember, it does have a mesentery, both right and left side in a large number of cases. I think those who open the bowel very often realize many times the colon has a mesentery all the way around. The point that all brings up to me is simply this: We cannot depend on the location of the large bowel.

DR. THRAILKILL—The Doctor presented us with a most excellent paper a subject of great interest to me. In taking up the etiology, he failed to mention floating kidney as a cause. About five years ago I had a lady with colitis who had been treated by some of the best doctors in the east, with no benefit. I treated her for two months with but little improvement. Nothing seemed to help her until she fell into the hands of the general surgeon who holds the kidneys responsible for about all the diseases in the abdominal and pelvic cavities. In this woman he found a floating kidney, anchored it and cured the colitis.

The colitis is brought about by the kidney pressing against the colon in its descent and ascent with the movements of respiration. Also extra-colonic adhesions and growths will sometimes cause colitis. In the former the colon is fixed at this point allowing the movable portion above to telescope into it, partial intussusception, causing irritation resulting in colitis. I have a patient in my hospital now in whom this condition exists.

In extra colonic growths we have an obstipation, the lumen of the colon becomes very small, resulting in irritation and ultimately colitis. The essayist spoke of the nervous element accompanying these cases. I wish to say that they are more pronounced in these cases than in the membranous variety.

In taking up the treatment will say that I derive more benefit from coarser foods. They collect and remove the mucus and fecal crumbs along the canal. In France they give these patients large quantities of pop-corn for this purpose, and claim to cure colica-mucosa with it.

Pressley, of Birmingham, Ala., claims to cure not only colitis but

amoebic dysentery with turnip top greens. I gave it a thorough trial but it proved a failure in my hands.

I have no use for a colon tube, not one time in 50 are we able to get one into the sigmoid. For colonic irrigation I use the Wales bougie No. 6 or 8, the patient in the knee chest position.

The solution employed in the cases depends on the stages. In some cases I have them use the irrigation after they have retired in the Simms position with hips elevated and not get up after using it. As my time is up I will not be able to take up operative interference in these cases.

DR. H. L. SNYDER—(Closing the discussion)—There is a mesentery to the descending colon some of the time but I said nearly all the time it was without. I also grant the fact that this water and fluid flowing out of the head of the colon is due to reversed peristalsis. We know it takes more than two quarts to fill the colon.



DR. C. C. GODDARD, Leavenworth,  
President Kansas Medical Society Ensuing Year.

## THE PHYSICIAN'S RELATION TO MENTAL HEALING SYSTEMS AND METHODS.

By REV. SOLOMON S. HILSCHER, Iola, Kansas.

Read before the Kansas Medical Society at Iola, May 7, 1908.

It seems like presumption for me to appear before this body of learned men and to attempt to give instruction on any question connected with the healing art. But if my appearance before you today is an act of presumption, you must charge the same to the Allen county Medical Society, by whose unanimous vote I was asked to be here and to say to you what I said to them. I trust that it may be of interest to you and very suggestive, though I have but little hope of saying anything that has not already come to your attention.

What I say I shall put in the form of certain propositions, and then indicate the line of argument that would have to be pursued in proof of the same. I shall address myself at once to this work, believing that in this way I can best indicate:

The Physician's Relation to Mental Healing Systems and Methods.

### PROPOSITION I.

Throughout the historic period remarkable physical healings are recorded as having taken place, said healings not possibly attributable by the modern thinker to any other cause than some action of the mind on the body.

To prove this proposition we would have to examine the records as to their genuineness, and to show that the alleged healings were **real** healings of **real** diseases. Perhaps few, if any who take this trouble, question the truth of the proposition. We do not refer to such healings as may be attributable to the use of some helpful drug or to the intervention of some supernatural agency. We refer rather to the numerous healings performed by so-called magic and black art, by witch doctors and medicine men among the savages, by visits to shrines and sacred places, by contact with bones of alleged saints and with sacred relics, by the use of amulets and charms, and by the practices of a horde of "quacks" ancient and modern. There healings must be due to some action of the mind on the body.

Dr. Pye Smith said that the much talked of "*Vis Medicatrix Naturae*" was a figment owing its popularity to its latin dress.

Others have made much sport of this alleged something. But this something cannot be laughed out of court even by a famous physician. There is something in the body that heals and a study of

the modern discoveries will compel one to say that this "something" is the mind.

#### PROPOSITION II.

These strange healings are of numerous kinds and stages of real diseases, not merely of imaginary ills, but of diseases both functional and organic, though much more common among the distinctively nerve diseases.

In proof of this proposition we would again have to search the records and cross-examine most rigidly the witnesses. But the books are filled with the most undoubted testimony and many living witnesses, most carefully and scientifically trained, could be produced. These witnesses have not been deceived. It does no good to laugh at the alleged healings as having been only of imaginary diseases. One can not read such books as "The Unconscious Mind" and "The Force of Mind" by Dr. A. T. Schofield of London, and many other books from the pens of some of the best physicians of modern times and not be convinced that this "Something" that is in man is responsible for the complete healing of the most terrible diseases even when no medical attention had been given, or when all medical skill had failed.

#### PROPOSITION III.

The science of Psychology has established the fact of the dual nature of mind. Mind is more than consciousness. Mind is both "conscious" and "subconscious". The subconscious mind is especially amenable to suggestion and will usually act with faultless logic on the suggestion. Mind has a subtle and powerful influence over mind, perhaps even at a distance.

A persons own conscious mind, or the conscious and subconscious mind of another person, will powerfully influence his suggestable subconscious mind.

This proposition takes us into the vast and largely unexplored field of psychology. Men have learned enough of the mind to find out how much more there is to be learned.

But that the propositions in its various statements is true, perhaps none will question who have taken the time to study the subject. To prove the proposition we would have to resort to the facts of psychological investigation.

#### PROPOSITION IV.

The subconscious mind stands most intimately related to the entire physical organism. It regulates, controls, guides, and arranges all of the involuntary actions and activities of the body. All of the processes of digestion and circulation, of excretion



and secretions, of repair and waste, and all such like processes, are under its control.

A voluminous number of experiments made by the most careful and most scientific investigators unquestionably prove the truth of this proposition.

#### PROPOSITION V.

It is a fact of physiology and of psychology that when a powerful suggestion of health or of sickness is given to the subconscious mind, it is quick to act on the suggestion, and it seeks to reproduce in the physical organism the conditions indicated by the suggestion. The experience of ages could be produced here in evidence, as well as the testimony of modern investigators. Here a vast field remains to be explored. Is the power of the suggestion to be found merely in the verbal utterance, or are there certain soul forces as yet unknown that are turned loose by the suggestor, which operate according to unknown psychic laws? We must remember that a suggestion given in the same words by different persons, has different degrees of power.

#### PROPOSITION VI.

Numerous mental healing systems have been developed of late years, using the same or different methods of practice, and they have to their credit numerous and astonishing cures.

The testimony here is that of current history. Nearly every city of any size in this country and in Europe has its mental healing practitioners. Some of these are allied with some religious scheme, many others are not. They have numerous patients and many genuine cures of real diseases to show for their efforts.

#### PROPOSITION VII.

These different systems in many cases have different theories as to the source of their healing power. These theories are often diametrically opposed and mutually exclusive, yet this does not seem to interfere with their performing cures. It is therefore evident that all these theories are not correct, and that there is one fundamental cause of healing underlying all these systems and methods of practice. Here we would have to put on the witness stand the events of current history and the rules of sound logic.

#### PROPOSITION VIII.

Many of these systems, because their advocates are ignorant of the source of the healing power which they evidently exercise, are established upon theories of causes that do violence to the testimony of common sense and human consciousness, and that also deny the fundamentals of revealed truth. These systems nevertheless produce some genuine cures, which is positive proof that the

real cause of the healing is not to be sought for in the field of consciousness or in the sphere of religious truth.

This proposition can be maintained by citing the facts of history, of sane Bible interpretation, and the laws of true logic.

#### PROPOSITION IX.

The healing of mental healers of every school, the healing produced by quacks of every sort, and a very large part of that to be placed to the credit of the trained physician, has as its basis the subconscious activity mentioned\*above.

This is given as a proposition to be proved, not as a dogmatic statement or an axiom. Multitudes of physicians and psychologists would freely give their experience and the evidence of their experiments in proof of the proposition.

#### PROPOSITION X.

Without doing violence to the testimony of common sense and human consciousness, without denying a single truth of revealed religion, without rejecting the proper use of a single drug that may have therapeutic value, or a single mechanical device that has been found helpful, it is possible to arouse the subconscious activity to the healing of the body. The evidence to be produced here is simply overwhelming.

#### PROPOSITION XI.

An enlightened common sense, an intelligent use of the testimony of consciousness, a strong religious conviction founded on a rational interpretation of revelation, and the proper use of certain drugs and appliances, may all conspire to arouse subconscious activity.

Such a work as that carried on in what is known as the "Immanuel Movement" in Boston, and many other kindred movements might be cited here as proof.

In the light of these eleven propositions I desire to lay down several others showing what I believe to be the physician's true relation to mental healing systems and methods.

#### PROPOSITION XII.

The physician should be a trained psychologist as well as a trained physiologist. He should be as thoroughly versed in the laws of the human mind as in those of the human body.

Hippocrates was a student of psychology, and so was Galen and nearly all the great physicians whose names adorn history's pages for thousands of years. No physician who has kept pace with the modern thought and discovery will ask for much proof here.

#### PROPOSITION XIII.

As a trained psychologist the physician should make a careful study of the different mental healing systems, however sensible

or absurd, and of the different methods of practice however ridiculous. And why? Because it is possible that quacks and ignorant men may stumble onto some truth in the field of the psychic. The truly scientific man is an investigator and moves slowly, awaiting all kinds of proofs before he will consent to say much. The quack will take the cautiously expressed suspicions of the scientist and declare them as facts and at once put them to work. This is especially true in the psychic realm. It may be true that the quack "metaphysician" is actually using a psychic law to the healing of the body. The physician should learn his secret, if he has one, and use it scientifically.

#### PROPOSITION XIV.

The physician should not hesitate to use the **methods** of mental healing, when found to be true, even though they may have previously been used by quacks and by advocates of systems also in their theory of causes.

No man is better fitted by profession to rescue from the hands of quacks what is true in mental healing, to discover proper methods of mental healing, and to make the matter a true science, than is the physician who will apply himself diligently to the study of the mind as well as the body. The psychologist in his psychological laboratory may make great discoveries, but the intelligent physician can put these discoveries to work in a marvelous manner, and by his close contact with both mind and body of the sick, he can become a discoverer himself. Here is a recent statement of Prof. Elmer Gates of the Psychological Laboratory at Washington, a statement which he bases on numerous experiments, and which he gives expressing scientific facts. "Every mental activity creates a definite chemical change and a definite anatomical structure in the animal which exercises the mental activity. The mind of the human organism can, by an effort of the will properly directed, produce measurable changes of the chemistry of the secretions and excretions. If mind activities produce chemical and anatomical changes in the cells and tissues of the animal body it follows that all physiological processes of health and disease are psychological processes, and that the only way to inhibit, accelerate or change these processes is to resort to methods of properly altering the psychological or mental processes." "Note the learning that this discovery has on all that has been said above."

#### DISCUSSION.

DR. JOHN PUNTON—I don't feel Dr. Hilscher needs any apology in appearing before this society on such a subject as this, for I think he has already demonstrated he is far ahead of many physicians in the State of

Kansas and Missouri today with reference to the study of psychology. I am sorry to say, if there is any one study more than another that is neglected by the average doctor, it is the study of medical psychology, and I only regret that such a paper as this has been left to a preacher rather than a doctor. These are the very papers that are needed to be read today in all our medical societies. It is a burning question, this question of the treatment of disease by psychological means, and the average doctor of today is not alive to the fact that the mind cures disease. It would take me too long altogether, you would get out of patience with me, if I should attempt to answer all the propositions the Doctor has laid down here, and they are all worthy of attention. He has summed up in this brief paper the attitude of the scientific psychologist of today with reference to the influence of the mind on the body. He has taken the pains to sift it all down and give us in a nutshell what every doctor really ought to know with reference to that subject. I have been very much interested in this ever since I began to study nervous diseases, and I want to tell you that the physician that attempts to practice medicine today without a knowledge of the mind and its influence on the body is illy prepared to practice in the modern 20th century. There is not any doubt but what the mind is a dual organ; there is not a doubt but what consciousness can be divided into two parts. In other words, we have what is known as the conscious mind and the sub-conscious mind, and this sub-conscious mind it is which plays such an important role in the influences on diseases. The doctor in his paper takes the pains to give us the scientific results that he has boiled down into a few remarks by stating that it can influence not only anatomical changes but chemical changes in the body, and there is not any doubt of it. If the mind in its normal condition can influence the body to such an extent as that, what part can it play in influencing disease. It can do a whole lot, and a great deal more than most men think.

And I want to say in this connection I don't think we physicians should feel that we are using anything unethical that pertains to the cure and the alleviation of suffering, even if it is the most potent measure that the quacks are using today. I believe that scientific medicine and therapeutics is large enough to take in the entire realm of all measures that alleviate and cure disease. I think we are inclined to be too narrow in our therapeutics today. I think there is not a single physician in the State of Kansas that does not recognize the fact that there are certain diseases, more especially functional nervous diseases, that are not amenable solely to the influence of drugs.

Much as I admire drugs, I believe there is not a man before me that does not realize the fact, that has had any practice at all, that there are certain nervous diseases, even though granting they have an organic disease, that surgery will not cure them, even though they submit to an operation; and that then there are certain diseases which you and I are coming in contact with from day to day that are not amenable to either drugs or surgery—what is left, the realm of psychological therapeutics which the doctor in his paper beautifully illustrates. I wish I had time to enlarge more on this subject but I feel I have taken more time than belongs to me, and I want, in closing, to emphasize one thing with reference to the study of medical psychology—what we need more especially in the practice are men that not only know something about drugs and microscopes and refined laboratory methods but we also need men that can combine all of these with the influence of mind on the body. In other words we want men that understand the relation of mind to body, and its influence in disease. You can get a thorough acquaintance with that by reading this book he refers to, "The Force of Mind," by Schofield.

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DR. L. R. SELLERS—I was very much interested in the paper; I hope some time that paper will be published so I can sit down and study it. I believe there is a limit to this. I think the mind bears a certain influence over the physiological functions of the body but whether it does over the real pathological functions I doubt. Take a boy who runs a pin in his hand, there is nothing can convince him that does not hurt. But the influence of one mind on another mind, a strong mind on a weaker mind has about the same influence a splint does to a broken bone. My work is in the Osawatomie



State Hospital. We are treating insane patients and we use everything and study everything in the way of suggestion; we try everything of the kind, and I have never known that they have ever done anything for any bodily function. When I try that I always think of Dr. Carson, of Kansas City and I quit, but a whole lot of these insane people would behave themselves if their neighbors would behave themselves. A woman starts out and she says everything is upside down, and the neighbor comes in and says "Yes, dear, they are upside down, your husband will be home in a little bit and we will straighten those things up." "They talk baby talk to them. If a strong minded person would come in and say "This is all nonsense, don't repeat that any more," they would get that idea out of their head. I have seen a patient come into the hospital with handcuffs on and ankles tied together, raving, and I commenced talking with her—"I'm at a loss to know just where to put you; I have eight wards, and I have got some nice, clean wards where it is all nice and quiet and I have some intermediate wards and then I have some where I put all the patients that make terrible noises," and she says I don't think I would like to go in with noisy people," and I says "When I sign up this receipt for the sheriff I will talk with you," and I turned around in a few minutes and she said "I can be quiet," and I says "All right, I will put you in Ward A" and she stayed in Ward A until she went home. I said to her a few days after that "Why is it you can be so quiet?" and she says "Somehow I thought I had got some place where I had to. At home they let me do as I pleased,"

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DR. M. L. PERRY—I don't know when I have heard a paper that was so timely as this one. It is something that all physicians can take a moral from. If there is one class of people anywhere that ought to be broad it ought to be the physicians from the very nature of their study, and yet we find a great many physicians who are narrow, and many physicians who will not attempt things which are beyond question. I believe we can do a great deal toward combatting the quacks and our friends the Christian Scientists if, instead of antagonizing them so much, if we attempt certain things that are now recognized. I think some of the things these people claim are really true but they make an error in going to the extreme. I believe by such a course we can do much to prevent some of the bad effects they accomplish in their efforts to cure everything if we admit they can cure some things by suggestion, but they cannot cure everything, we can convince many people that would otherwise believe them entirely. One is impressed with the importance of the subject the more he studies it, the influence of mind on the body, and anyone who has read that old standard by Dr. Pugh on "The Influence of Mind on the Body" must certainly recognize it has a place in medicine. I would also recommend to each and every one of us the study of the recent work of Dubois on "The Psychological Treatment of Disease." These men have made studies of this subject and point out many things that can be accomplished by suggestion which we fail to get by rigid adherence to drugs.

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DR. S. S. GLASSCOCK—I was very much interested in the Doctor's paper because it brings out the subject to the medical profession it is well well for us to understand, the great mistake, I think, that is made by our friends, the Christian Scientists and mental healers and people that use pulverized bone and all those things. What we as the medical profession want to do is not to make a great hurrah about homeopathy or osteopathy, but to get busy and do our part of the work. The thing we want to impress on the public is that the influence of the mind on the body is a valuable thing, but it is not the only thing in medicine, but if we attempt to suggest the idea that it is the only thing in medicine we lose sight of the most important thing we could have. It would be the height of folly to talk about treating a broken leg with psychology; you have got to put your splints on and get them in proper position. The effect of mind upon the body in keeping the man in good spirits and in good condition and under favorable influences might exert, and no doubt would exert some influence in hastening the healing of it, and yet without the splints it is absurd to talk about it. Just take syphilis, for instance, a man would be crazy to talk about treating it without the iodides

and mercury, and yet if, combined with your remedies, you have the suggestion; of course you are going to get benefit from that suggestion. Take the progress made in the last few years in toxines, and the man today is insane who believes for a minute you can treat diphtheria in any other way except by the use of the toxines. The death rate has been so enormously reduced, yet the influence of the confidence the patient has, or the suggestions you make, exerts a wonderful influence. We see many men not classical scholars, that don't have a great deal of information, and yet there is a power in that man, not because of his learning, but when he comes into a sick room he inspires confidence. He does not say to the patient that has Bright's disease, "You are going to get well in a few days;" he does not say to the man with diabetes "You are going to get well in a little while, but he has that thing the Christian Scientists don't have—he selects the case he is going to use that means of treatment, and if he has a hysterical case there is a chance for it to get well, and he applies his mental healing power to that case, and when that man comes into the room, the patient all scared and worried, just as soon as he comes into the room there is that power of mind over matter that operates on the patient, and it is a thing you cannot possibly do otherwise.

In the treatment of mental and nervous diseases it is not a matter of what drugs are given to them, but there is a power of influence or suggestion there, that they must not do certain things, that they have delusions in their minds, you must disabuse them and let them alone, apply means of feeding and all these other things, but the suggestive power of influence just on the patient and the power you have to disperse these delusions and get their minds straightened out and get them to quit talking about them, and lead them on to the point where the delusion disappears, the influence of that in medicine is remarkable; but what I want to do is to say to these people that are using it in the form of quackery, it is not the only thing in medicine, it is one of the things and only one. Of course we cannot dispense with the laboratory—there is nothing that has aided the medical profession to a better understanding of disease, but the laboratory, the microscope, drugs and all these things added together makes it a great profession, and instead of ridiculing these methods the way is to look into them, as the Doctor states, and select the one thing they have and do it according to our light, and it will soon be a thing of the past.

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DR. C. C. GODDARD—I think it is too bad the preacher had to come on and tell you fellows something. You will probably believe him but you will not believe others. My feeling is that the general practitioner has at least what I would call two delusions—he is a delusionist—the surgeon is a radical, and then there is the psychologist. The general practitioner who thinks he knows something, he has an idea he gives drugs for a certain purpose, but he cannot explain what his drugs do nor why they do it; if anyone else gets up and says there is something else back of it he laughs and makes fun of it. The surgeon is radical because what he cannot cut out cannot be cured, and he has an utter disgust for the psychologist and the general practitioner. We talk about drugs having effects, but we don't know why they do it. We have theories but you don't know any more about it than you do about what the newlons(?) do and you don't know anything at all. Talk about mind and psychology, you don't know where the mind is, you don't know what the mind is nor where it is; we suppose it is in the brain, we hope so, but if it is there why cannot we take it out, why cannot we find it, why cannot you take a fellow's brain out and print it—the pictures are all there and everything he knew is all there, why cannot we print it? You talk to a man about the objective and subjective mind, add something about the subliminal and subconscious mind and he smiles. You get to talking to half the men in this room about the subconscious mind, and they will go off on the quiet and say "That fellow is nutty." I don't know but we are all getting "nutty," the more we study it the more "nutty" we get. We are all crazy, and especially if we get to studying psychology. The fact of the matter is, I never saw anybody that wasn't crazy; but then his thirteenth proposition about these quacks and things was quite a good point there. Find out what these people are using and use it yourself. Don't condemn those things and laugh at them and say "He is a fool." If you have inves-

tigated it, all right, crow, but don't brand yourself as an ass by condemning something you don't know anything about.

DR. JOHN PUNTON—I would like to correct an impression Dr. Goddard left. He gives out the idea all men are crazy; that is not a scientific view at all. I want to defend the science of medicine against any such connection as that. I believe there are insane men and I believe there are sane men and I believe many of them are here today; and the second proposition is this: The Doctor has an idea that because we don't know what mind really is, that we ought not to have anything to do with it. We don't know what electricity is, we don't know what life is, there are many things in medicine we don't know what they really are in essence, but we know what they can do. We know electricity will drive the cars and light and heat our homes. If we know what the mind will do, that is all, it seems to me, from the scientific standpoint, that is expected of us—that is all that is claimed by scientific psychology, that while they don't fully understand the essence of the mind they do know what it will do.

DR. S. S. HILSCHER—(Closing the discussion)—I would emphasize my view of the physician's relation by stating just a few words I stated in a lecture at Girard a few weeks ago. A certain man from somewhere who represents a certain lady who lives in Boston, had been in Girard and gave a free lecture and the physicians of Girard I don't know whether any of them are here or not hearing of me through the Presbyterian minister, who had heard a lecture I gave on Metaphysical Quackery, asked me to give that lecture. In that lecture—I had never thought of it before—but I used it, and will use it hereafter and use it here. Here, for instance, is a lady in her home; she keeps a maid, and the maid's business is to keep the floor cleaned up and the dishes out of the way and everything in shape. That is her business, but she gets a little bit lazy and she doesn't do it, and there is a little dirt under this table, and some cobwebs, and the curtains out of the way, and some old dishes over yonder, and finally the lady of the house has to go for her and say "Clean this thing up," but the lady of the house may neglect that so long, and the house maid get so lazy after while it is just simply beyond her power to do it, and you have got to call in a half dozen other women and have a regular house cleaning. We have this subconscious mind, whose business is—I believe psychological men say that—the business of the subconscious mind is to carry off the waste material and keep this house in repair; it gets a little bit lazy and we have to arouse it a little, but some let them go so long we have got to call in some help. We will send for a doctor, and you know we have let the house go so long it gets all full of bugs and things of that sort and you may have to call somebody to squirt bug powder all through the house—and this house may get all full of bugs, or microbes, and you have to squirt something into this house.

I said I believed this was the rational thing for any person to do. As soon as you feel a little bit bad don't send for a doctor—I have heard doctors complain time and again about it, saying they called me out today somewhere when there wasn't anything the matter—of course they got their fee. First when you feel yourself not feeling right, don't say you are not sick, because you are, but throw the thing off, and if you cannot do that very well, get somebody else to say to you "You are going to be all right." Why, you know, we all know, if we would go one at a time and tell this man privately that he was looking sick, we would have him in his grave inside of 24 hours almost, so we can anyhow tell people they look well, and if that don't work, the next scientific thing to do is to send for a physician, the man who understands this human body, then if he is a psychologist as well as a physician, I believe he will begin to do wonderful things. I believe the man who don't make a study of psychology, and an increasing study of it, keeping up with the advancing study of psychology in ten or fifteen years is going to be kind of back number, and I believe the physician is the man to take the thunder away from the Christian Scientists and all these other things.

On motion, duly seconded, it was unanimously voted that The Kansas Medical Society extend a vote of thanks to Dr. Hilscher for his paper.



# THE JOURNAL

## OF THE

# Kansas Medical Society.

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JAMES W. MAY, - - - - EDITOR.  
J. E. SAWTELL, ASSOCIATE EDITORS CHAS. S. HUFFMAN.

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Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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OFFICERS OF THE SOCIETY.—C. C. Goddard, Leavenworth, President; E. E. Liggett, Oswego, 1st Vice-President; G. W. Goss, Sedan, 2nd Vice-President; B. M. Barnett, Rosedale, 3rd V-President; Charles S. Huffman, Columbus, Secretary, L. H. Munn, Topeka, Treasurer.

COUNCILLORS.—1st Dist., Chas. W. Reynolds, Holton; 2nd Dist., H. B. Caffey, Pittsburg; 3rd Dist., F. M. Daily, Beloit; 4th Dist., O. J. Furst, Peabody; 5th Dist., O. P. Davis, Topeka; 6th Dist., J. A. Dillon, Larned; 7th Dist., Preston Sterritt, Kansas City; 8th Dist., A. L. Cludas, Minneapolis.

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## EDITORIAL

Every article published in this Journal is first submitted to the publication committee for approval. Any author wanting an article published should send it to the editor or publication committee.



Is there not too much commercial spirit in the reading of papers at the annual meeting. It seems a great many attend for one day, read their paper and then depart. This is not treating the other man right. A great many attend the Society during its entirety and take part in the discussions and proceedings, and if they have a paper scheduled for the last day there is only a corporals guard to hear it. True, many cannot get away for the entire meeting, but a vast majority of us can. Hereafter, in all probability, the meetings will be confined to a two days session and this in itself will help largely to correct this trouble.



The collection of dues for our State Society should be a prime duty of every county secretary in the State. The number of members paid up and in good standing exceed any previous year in the



history of the Society and the time should come when every member is paid up and in good standing. When we realize what a great deal of good is being done by our Society in improving the medical situation, it seems that the payment of dues to carry on the work should be a matter for every county society to take up and force to a successful issue. In this connection it can also be said that no one can belong to the American Medical Association who is not a member of the State and County Societies.



Our memory is refreshed by the prevalent exploitation of Bier's hyperemic therapy, to a case of diabetetes accompanied with huge abscesses of the back and buttocks, in the year 1893. The patient, a woman, had a most aggravated case of diabetes mellitis. Abscesses formed, resulting in ulcers. The abscesses were very slow and sluggish in forming, being very painful during the pre-ulcerous stage. For some time the treatment consisted in the usual surgical regime; injections of per-oxide, etc. Several of the ulcers being of deep origin, and the process of treatment being very painful during the removal of the pus, which required a long time to accomplish, and with considerable nervous shock and depression to the patient, resort was made to the ordinary breast pump to facilitate and hasten the evacuation of exudate, and with very satisfactory results, both as to completeness and to the comfort of the patient. As the abscesses were developing, marked relief was given the patient by applying the breast-pump to them and producing suction thereto. A marked contrast was evident in the formation of the abscesses before the application and in those treated by suction. In the former instances the integument and underlying structures would become gangrenous even before the abscesses opened, while in the latter more natural abscess formation took place, and in a number of instances an abortive effect was produced, or a decided lessening in the area of the abscess was affected. This evidently was the application of Bier's hyperemic therapy, in its crudity, unperfected and not theorized. Its administration being from a purely mechanical standpoint. That any inflammatory process interferes with the normal blood, nerve and lymph circulation is certainly undisputed and any means employed to re-establish the natural nutrition of the part is a successful therapeutic measure. Without a proper blood supply; nerve and lymph circulation, the tissues assume a pathological condition. Surely all of us have noted the efficacy of hot applications, mustard plasters, blisters, massage, violent rubbing where indicated and have observed the hyperemia

produced in each instance. We have relieved the stasis which has been produced by the inflammatory process and allowed nature to reestablish its normal circulation to the diseased parts. We have augmented the arterial supply, stimulated the venous exit, increased the nerve and lymph nutrition and produced phagocytosis, nature's method of cure. That Bier's experimentation along these lines has been productive of much good is evident. Like the graduated dosage of medicine to meet the exigencies of each individual case, so in the hyperemia treatment must the same scientific application of this remedy be instituted. It is capable, in the hands of the careful practitioner, of accomplishing great benefit, especially in the chronic forms of specific inflammations.

A careful study into its merits, modes of application, and indications for its employment, will be followed by a satisfactory usage of the same.



Our Society at the last meeting indorsed Dr. Chas. A. L. Reed, of Cincinnati, Ohio, for the office of United States Senator. Below will be found a copy of a letter from the Doctor expressing his appreciation.

May 9th, 1908.

DR. J. E. SAWTELL, DR. S. J. CRUMBINE, DR. E. J. LUTZ,  
Committee:

Gentlemen:—Your cordial telegram on behalf of the Kansas State Medical Society, expressing approbation of my tentative candidacy for the Senate came while I was away. Still more unfortunately for me, I did not get it until after your meeting had adjourned and consequently could not thank you and all the members by telegraph.

May I ask that you now accept for yourselves and, through the avenue of your State Journal, convey to every member of the Kansas State Medical Society, my sincere thanks for their expression of approbation.

Whether the movement now on foot in Ohio shall result in my formal candidacy or not, I shall ever stand ready to serve the interests of the people in the broadest possible way, but more specially in every particular in which their interests are represented by and through the medical profession.

With renewed expressions of thanks, I am, gentlemen,

Very sincerely,

CHAS. A. L. REED.

**NEWS NOTES**

Dr. Anna Masterson, of Kansas City, Kansas, was re-elected Supreme Medical Director of the Triple Tie Benefit Association for a term of two years.



One of the most appreciated exhibitors was the Horlick's Malted Milk Co. Dr. Dunavan with his malted milk ice cream is always a necessary adjunct.



The program at the Iola meeting was as a whole the best one ever given. The program committee (Drs. Huffman, Sudler and Davis,) deserve unstinted praise for their efforts.



The banquet given the society by the Allen County Medical Society was a success in every particular. L. D. Johnson, of Chanute, acted as toastmaster. The following responded to toasts: Judge Oscar Foust, Preston Sterrett, Geo. H. Hoxie, O. P. Davis, Perl Barton and C. C. Goddard.



The MEDICAL ASSOCIATION OF THE SOUTHWEST composed of the following states:—Kansas, Missouri, Oklahoma, Arkansas and Texas, will hold its annual meeting at Kansas City, Mo. October 20th and 21st, 1908. This meeting is expected to be the best in the history of the society.



Dr. Levi Horner, of Wichita, had on exhibit a buggy top of his own invention which is adapted to either rain or sunshine weather. It seems the doctor has an invention which is of prime necessity to the physician doing general practice. It combines comfort, neatness and durability with a very small expenditure.



The following houses were represented with exhibits at the Kansas Medical Meeting: Horlicks' Malted Milk Co.; The Rain or Shine Buggy Top Co.; Hettinger Bros.; Physicians' Supply Co.; E. Fougera Pharmaceutical Co.; R. W. Gardner and the Pond Tampon Co.; The Cleveland Press Medical Book Co., and the Abbott Alkaloidal Co.

The NORTHEAST KANSAS MEDICAL SOCIETY will hold its semi-annual meeting at Atchison, October 8th, 1908.



The American Institute of Homoeopathy will hold its annual meeting at Kansas City, Mo., June 22nd, to June 27th, 1908.



PROGRAM RICE COUNTY MEDICAL SOCIETY:—June 18th, Sterling: Paper—Rev. A. O. Ebright; Quiz—Physical Examination of the chest, Dr. D. T. Muir; Strabismus and its Treatment, Dr. E. A. Bodenhamer; Paper, Dr. M. Truehart. July 16—Chase—Typhoid fever, Dr. J. S. McBride; Alcohol in Disease Dr. H. R. Ross; Conduct of Labor, Dr. J. H. Staatz.



The Medical Era, St. Louis, Mo., will issue its annual series of Gastro-Intestinal editions during July and August. In these two issues will be published between 40 and 50 original papers of the largest practical worth, covering every phase of diseases of the Gastro-Intestinal canal. Sample copies will be supplied readers of this Journal.



**ZYME-OID**—W. A. Puckner and W. S. Hilpert, Chicago, in The Journal A. M. A., May 23, give the results of the examination in the Association Laboratory of zyme-oid, manufactured by the Oxychlorine Chemical Company of Chicago. It is advertised as a "powerful gastrointestinal antiferment" which will arrest and prevent bacterial fermentation in any portion of the intestinal tract, whether the media be acid or alkaline." These extravagant statements, like many others made regarding the properties of zyme-oid, are very similar in character to those made in the circulars accompanying the preparation, oxychlorine, manufactured by the same firm and exposed in the Journal July 6, 1907, page 54. This analysis indicates that zyme-oid corresponds to a mixture approximately as follows:

Potassium chlorate (KClO <sub>3</sub> ).....	40.43
Sodium nitrate (NaNO <sub>3</sub> ).....	33.22
Potassium tetraborate (K <sub>2</sub> B <sub>4</sub> O <sub>7</sub> ).....	1.60
Sodium tetraborate (Na <sub>2</sub> B <sub>4</sub> O <sub>7</sub> ).....	3.31
Boric acid.....	21.14

From the results of the analysis and from the physical prop-



erties of zyme-oid Puckner and Hilpert conclude that the preparation is not a definite chemical compound, but is essentially a mixture of alkali chlorate and nitrate with boric acid, probably produced by fusing together the constituents.

In commenting on the report The Journal states that an examination of the claims made for the firm's two products, while disclosing many points of similarity, also shows one remarkable difference, namely, the skillful indefiniteness that pervades the claims made for zyme-oid, and which defies scientific refutation. This verbal obscurity is becoming daily more common in the "literature" of firms marketing nostrums. Since the Council has analyzed many of the much advertised articles and proved the unreliability of the pseudo-scientific claims made for them, the more cautious of the nostrum-mongers have modified the matter descriptive of their products. Wherever it was possible to put forward claims by implication rather than by expression this has been done. To substantiate further the claims made by the manufacturers of zyme-oid for their product, a laboratory report is brought in evidence. This report, which is written more in the style of a peruna testimonial than that of a conservative scientific statement, fails to verify the claim that zyme-oid is a "double borate salt," but confines itself to a statement of its harmlessness and its anti-fermentative properties. In passing, it seems regrettable that scientific laboratories should, for a pecuniary consideration, be willing to jeopardize their reputations by lending their names to the furtherance of nostrum exploitation. The results of the examination of zyme-oid demonstrate that the product is no more worthy of the physicians' consideration than its close, and equally worthless relative oxychlorine.

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## CLINICAL NOTES

**Syr. Hydriodic Acid** is a valuable agent in the treatment of all forms of bronchitis. It should be given to adults in teaspoonful doses every 3 hours.



**The application of cold** benefits a great many inflammations of the eye. The growth of bacteria is inhibited to a great extent. When the cornea is involved, refrigeration is usually not indicated.



It is very unwise to use hydrogen peroxide in an abscess of the middle ear unless there is a large opening in the drum, and even

then it is not a good treatment. The danger is very apparent, for when the peroxide foams up, it is likely to spread into the mastoid carrying the pus with it.



When giving potassium iodide and bichloride of mercury, the time of administration should be hours apart. Otherwise they would combine in the stomach and form the red iodide.



**Persistent high temperature** after appendectomy may be due to the formation of a pelvic exudate. No operation should be performed until a distinct localized abscess has formed, as there is danger of setting up a diffuse peritonitis.—Amer. Jour. Surgery.



When prescribing for any inflammation of the urinary organs, much better results follow the use of non-alcoholic preparations. Therefore medicines in tablet or pill form are preferable to fluid extracts, tinctures, elixirs or fluid proprietary solutions. The use of any stimulants should be strictly forbidden.



#### EYE WASH:

R   Acida   Borici.....grs xxx  
       Sodii   Boratis.....grs x  
       Aqua   Destillatae.....oz II  
 M. et Sig.:—Use freely in eyes four or five times daily.

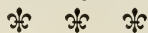


**Medical Treatment of Graves' Disease.**—Thompson (Amer. Jour. of the Medical Sciences, March, 1908) favors the medicinal treatment of Grave's disease. He recommends to every patient thirty grains of sodium phosphate, to be taken at the beginning of each meal, and a blue pill or other mercurial laxative to be taken twice a week. A course of intestinal antiseptics is then recommended, to be kept up for months at a time. He usually begins with sodium salicylate and sodium benzoate, of each ten grains, an hour after each meal. He prescribes for administration at bedtime a capsule containing naphthalene three grains and sodium benzoate six grains. After a time he substitutes a capsule containing phenol bismuth and ammonium benzoate, each five grains, of which two should be taken an hour after meals. The principle of these remedies as intestinal

antiseptics being understood, every physician can, Dr. Thompson says, vary the prescription as he finds best.—N. Y. Med. Journal.



Raising the foot of the bed twelve inches may combat shock more quickly than repeated administration of stimulants, and, by the way, is far less harmful to the patient. One should remember not to use this means in abdominal cases where pus has been found in the abdominal cavity.—Amer. Jour. Surgery.



**TETANUS TREATED WITH MAGNESIUM SULPHATE BY HYPODERMOCLYSIS:**—Morton Lyon, Dewitt, Iowa, reports a case (Jour. A. M. A., May 23) in which tetanus developed eight days following a nail puncture wound of the foot. The wound was treated with hydrogen dioxide and tincture of iodine, and the convulsion partially controlled by morphine, chloral and bromides. On the twelfth day he injected under the skin of the abdomen two drams magnesium sulphate in four ounces of distilled water, followed by improvement in two hours. On the thirteenth, fourteenth, seventeenth and nineteenth days the magnesium sulphate injections were repeated followed ten days later with recovery. It was necessary after the first week to give digitalis to improve the heart's action and tonics for the anemia.



**Tannin in Postpartum Hæmorrhage.**—In the Vaud, where the women lead very laborious lives and have very large families, postpartum hæmorrhage, due to uterine inertia, is of very frequent occurrence, and the country practitioner is at times at his wits' end for an effective method of treatment, the usual means—ergotin, massage of the uterus, bimanual compression, ice, injections of hot water, with or without tannin, and even plugging with gauze or the fist—having failed him. In such a case Renaud (*Revue médicale de la Suisse romande*; *The Practitioner*, April, 1908) tried the effect of gauze powdered with tannin, and the effect was almost immediate, although the uterine contractions remained very weak. He therupon had prepared some gauze, impregnated with ten to fifteen per cent. of tannin, which was cut into suitable lengths for packing the uterus, and then sterilized by high pressure steam. These are packed in parchment paper, which keeps them aseptic, portable, and ready for instant use. He has made an extensive use of this hæmostatic packing, and has always obtained a successful result, with

rapidity and certainty in cases of postpartum hæmorrhage, and also in cases of severe metrorrhagia at the menopause, in which packing has been necessary. As the dressing is "hæmostatic" and not "antiseptic," every care must be taken in introduction to avoid soiling against the labia and external parts of the genital region, and the packing should not be allowed to remain in the uterus for more than from twelve to twenty hours. This allows ample time to insure firm coagulation.—N. Y. Med. Journal.

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## PROCEEDINGS

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### Of the Forty-Second Annual Meeting of the Kansas Medical Society at Iola, May 6-8, 1908.

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#### MEETING OF HOUSE OF DELEGATES.

AT IOLA, MAY 5TH, 8 O'CLOCK P. M., IN ELK'S HALL.

House called to order by President J. E. Sawtell, with C. S. Huffman, Secretary.

The minutes of the last session read by the Secretary, and there being no corrections, were adopted as read.

Upon the roll being called, a quorum were found to be present.

#### REPORTS OF OFFICERS:

The Secretary's Report was read by C. S. Huffman, as follows:

#### SECRETARY'S REPORT.

I respectfully submit the following report to the House of Delegates, for the year ending May 4, 1908:

The usual good interest is maintained in most of the organized Counties. Since making my report last year, there has been two new organizations, viz: Pawnee County Medical Society and the Tri-County Medical Society, composed of Seward, Meade, and Clark Counties. There are still two counties in the eastern part of the State that we are not able to bring into the fold, viz: Franklin and Morris Counties. Franklin still has a good organization, but has never become a component part of the State Society.

The organization as it now stands:

Total number of County and Multiple County Societies.....	69
Total number of Counties organized.....	99
Total number of counties not organized.....	6
Total number that have paid dues for the year 1908.....	948
Total membership on the books of the Society.....	1517

Notwithstanding the financial depression that existed during the past year, we have more members who have paid up, than at any time before in the history of the Society, and the financial report will show that we are on a solid financial basis, with a good balance in the hands of the Treasurer.

The editorship of the Journal was changed again this year. Dr. J. W. May, of Kansas City, was elected Editor, by the Council, and I feel that it was a good move to have the Journal published in one of the larger cities, for several reasons. One is, that better facilities can be had for printing; another is, a better class of advertisements can be obtained, making the expense of publishing the Journal much lighter on the Society.

The contract with Dr. May, relative to the publication of the Journal, will be found in the report of the meeting of the Council held in Kansas City, on March 18, 1908.

I would like to call attention to the fact that our Medical Law should be



amended in many respects. It was amended at the last session of the Legislature, and strengthened materially, but there is still much to be done before the Medical Law will be strong and command the respect that it should.

I wish also to mention the fact that in selecting the officers for County Societies, the men who are selected to fill the office of Secretary, should give special attention to the duties of that office. I find in Counties where we have a live, wide awake Secretary, there we have the best Society and the best results are obtained.

I want to again call the attention of the delegates to the importance of having the County Secretaries make prompt reports of deaths of members to the State Secretary, that such notice may be given suitable recognition in the Journal.

I wish also to commend the efforts of the Council during the past year. Many of them spent much of their valuable time traveling over their districts and inspiring the different County Societies with renewed efforts.

#### FINANCIAL REPORT.

Amount of dues collected for the year.....	\$2209.50
Amount received on advertising and miscellaneous items.....	1096.43

Total.....	\$3305.93
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Amount turned over to Dr. L. H. Munn, Treasurer.....	\$3305.93
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Amount in Dr. Munn's hands at last report.....	4053.05
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Total.....	\$7358.98
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Amount paid out on general account.....	\$1568.66
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Amount paid out on Journal account.....	1374.11
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Balance on hands.....	\$4416.21
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Respectfully submitted,

CHAS. S. HUFFMAN, Secretary.

Thereupon it was moved and seconded that the Secretary's Report be accepted and placed on file. Motion carried.

Thereupon the report of the Treasurer, Dr. L. H. Munn, was read by the Secretary, as follows:

#### TREASURER'S REPORT.

Mr. President and Fellows of the Kansas Medical Society:—

I have the honor to submit the following report:

Cash on hand May 5th, 1907.....	\$3953.05
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Cash received up to May 6, 1908.....	3305.93
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Cash paid out up to May 6, 1908.....	2842.77
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Gain during the year.....	463.16
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Cash on hand May 6, 1908.....	\$4416.21
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L. H. MUNN, Treasurer.

#### REPORT OF THE AUDITING COMMITTEE.

We, the Auditing Committee, have examined books and reports of Secretary and Treasurer and find same to tally. The apparent discrepancy of one hundred dollars is due to the Treasurer accounting for same in 1907 and Secretary in 1908, but check even in final account.

P. S. MITCHELL,

R. A. ROBERTS, Committee.

#### REPORTS OF COUNCILLORS.

##### FIRST DISTRICT, C. C. GODDARD.

I have no particular report to make. We made our reports at the Council meetings during the year, and we perhaps didn't realize we had to make them to the House of Delegates, except being on that Committee on interviewing the "Eagles" at Iola, and the Committee to find out what could be done, what should be done. We were helped in every way by the local fraternity, and finally we all concluded it was best not to allow ourselves to be

known as absolutely delegated by the State Society with any power to act, that we simply came down on a tour of inspection, or to find out what could be done in the future; but we had a meeting with a committee of "Eagles" and discovered that the Aerie physician business was a local thing, and residing in the community in which it existed, and was not a part of the state constitution, that is, positively I mean the Aerie physician. They examine all applications for membership but the treating of members is optional by the Aerie in which they reside.

It is not compulsory with the Aerie; they can employ whom they please, or they have the option of appointing a man, and we could not see any way whereby we could exert any control over their appointing of those physicians, as the chief physician told us it was entirely optional with the local body and was not a compulsory part of the constitution, and we concluded, Dr. Jarrett and myself, to report that we did not deem it advisable to enter into any representation at all with the "Eagles" as a State Medical Society. We thought it would be rather against the Society's standing to meddle with any such thing; it would confer no particular good on the society or its reputation. So far as our District is concerned, our counties are all in good standing and should have had their dues all in; they may not be, I don't know. The first district Societies are all well to-do, and the membership has been increased during the past year.

#### SECOND DISTRICT, HUGH B. CAFFEY.

As Councillor of the Second District, I respectfully submit the following report: The Second District is composed of the following ten counties: Allen, Bourbon, Crawford, Cherokee, Labette, Linn, Montgomery, Neosho, Wilson and Woodson, all of which are organized and holding regular meetings.

Allen County has a membership of thirty-five and meets once a month. Crawford County has been meeting monthly in Pittsburg in the evening, but at its last meeting decided to meet at 1:30 in the afternoon. Cherokee County selects its program for the year in advance, giving only one subject for each meeting and naming the member who will be expected to lead in the discussion. This, I believe to be an excellent plan, and would like to see more of the Societies adopt it.

The Labette County Society is in good condition and holds its meetings monthly. Montgomery County gets out an annual program in advance and four members are assigned for papers at each monthly meeting. This Society is in a flourishing condition with a membership of forty. Neosho County is well organized, meets once a month and usually has only one paper for the meeting. Wilson County has its meetings every second month, beginning with February. Woodson County holds its monthly meetings at Yates Center. Linn County has a membership of eight and meets four times during the year. While our district has nothing for which to make great claims in the way of achievements, still I am glad to report all is well in good working order, and I believe the coming year will be one of good work and great success in perfecting our organization.

All except three of the Counties in my district meet in the evening. We have had some discussion as to whether it was advisable to hold meetings in the afternoon or evening, and whether once a month was too often to meet, or often enough, and also whether more than one paper should be given at each meeting. I think the conditions influence these points very much as to whether the County is sparsely settled, or whether there are any large cities in the county, or cities of good size, but I would like to have this matter discussed by the House of Delegates or before this body, if we can get to it, and point out some method by which all the physicians in the county may be reached, and I would like to hear the experience of some of the other Councillors on this matter, whether they meet in the evening, or whether they meet in the afternoons, and which has proven the most profitable time to meet.

#### THIRD DISTRICT, F. M. DAILY.

Mr. President and Members of the House of Delegates:—The Third District consists of twelve counties, all of which have been organized for the past two years, and I am unable to say whether they are all in good standing so

jar as remitting their dues promptly at the beginning of the year. So far I am acquainted with the work of the different Counties, their meetings are all held quarterly—I don't know of any of them that hold their meetings oftener than every three months, and they are, as far as I have been able to learn, well represented, at least the majority of the members of each county are present at each meeting. Our own County, I can speak for that—We have at least three-fourths of the members at each of these quarterly meetings, and two papers we find covers the entire afternoon's work, calling the meetings about half past two o'clock, it makes it rather late, and I think perhaps it would be better to limit the number of papers to one rather than two, and give a little more freedom to a more thorough discussion. The plan we have gone by, and the one adopted in our own county, and advise our neighboring counties to do like wise, is to have at the December meeting of each year, a general turn-out, and after the election of officers, to repair to some of the physicians homes and have a banquet, and we find that to be one of the most interesting meetings of the season. In fact, it brings out a good turn-out and we make a special effort at least to have our Secretary try to collect at that time, and he never fails to collect the dues for the incoming year from all the members present at that meeting; that is, at that December meeting. All those deficient, that is, the absent ones, for every week following, he sends them a statement once a week that they are the only ones, that they are holding up the dues to be remitted, and they are the only ones that are delinquent, and if they wish to hold their membership, which they certainly do, in the State Society, it is necessary for them to remit at once, and we have found it has not required more than three such notices from our Secretary to get any member to pay in the dues; and we tried to establish the precedent, and have in our own county, to not have our present Secretary turn over the books to the new Secretary until all these dues are collected and remitted to the Secretary of the State Society, and to request him at the time he turns over the books to be sure to make that precedent good, and I think if we had a good Secretary in every County in the State of Kansas we would have good County organizations. It appealed to me when I went about my district organizing, I began to look for the Secretary, I wasn't hunting presidents—they seemed to be the smallest part, in my estimation. We have found the men, and these plans have brought pretty good fruit over the third district. I am sorry to say that the Councillor has failed to comply with the letter of the law, and failed this last year to visit each county in the district, and I think that is one of the impossibilities for a busy practitioner to gather up courage enough every year to go to the far end of my district in a round about way. I think if he would circle around the way the railroads run, it would probably cover six hundred miles; we are not placed as the people down in the eastern part of the State with railroad conveniences, and while we have some good lines running across the State, we have to circle around in such a manner it is impossible, and it has appealed to me we ought to enlarge the number of Councillors in some way, selecting them along the lines of road that run through these different county seats. The status of the profession, I take for granted, in our district must be excellent, that is, in the matter of harmony and good feeling, for I have yet the first time to be ever appealed to for any disturbance or anything going wrong professionally with our people, and I am rather inclined to believe the situation in the third district is fairly good.

#### FOURTH DISTRICT, O. J. FURST.

I think this is the only time I ever wanted to be Councillor of another district, but Dr. Daily said my speech while he was talking. If I had come in in time I would have made the speech but he said it for me.

This Councillor District is composed of nineteen counties, all of which have been organized except Barber, and that is one of the western counties and very thinly populated, and very few physicians there and widely distributed, and it has been almost impossible to get them together unless a great deal of time was spent with them, and it takes quite a bit of time to do missionary work and get around to these nineteen counties once a year; and as I said, the doctor made my speech for me; I am just like him, I have not been there. I have been to quite a good many of them. I believe Harper



has not reported this year. I think they have gone back and they need another missionary visit down there. They have got two pretty good towns in the county and they are a little jealous of each other, the president is in one and the secretary is in the other, and they have a little feeling among themselves, but a little bit of work would fix them up all right again and it will come back again. There is quite a number of these counties with half of the doctors that are eligible to membership in the society in their society. Some of them meet every week, some of them meet once a month—I don't know as they meet every week,—once a month, and most of them quarterly. We have several societies that meet once a month in the larger towns. Meet once a month in Harvey county, and there they have nearly all the doctors in one town in the county, and they have a good society. They have nearly all the doctors in the county in it and they meet usually in the evening and they have a faculty of filling their stomachs quite often after they have their meetings, and they always have very enjoyable times as it is always the wee small hours in the morning when they disband. Most of the societies have two papers; they don't usually meet in the evening, outside of this one society. There has one thing developed I have thought a good deal of in these sparsely settled counties where there are four or five doctors in the town, they have organized a local society and meet every week, and those men get together and are brotherly and have a good time, and discuss their papers—they always have their papers every evening, and banquet about once a week, or go to one of the physicians' homes and spend a pleasant evening, and in that way have done a great deal of good, and I think it is along these lines we are going to get in a great deal of good.

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#### SEVENTH DISTRICT, PRESTON STERRITT.

The doctor on my left spoke about not being able to travel around. I will start my remarks by saying I have not had a chance to travel around, so I cannot say anything about the other societies in my district. I can say this for Wyandotte County Society, they have got a good sized society. We meet every Monday evening; we generally have a clinical report and generally one or two papers, sometimes three. I think it is by far better to have only a limited number of papers and go through them properly than to have a good many and not get through them right. In regard to the bad feeling is something I cannot appreciate at all. When I hear a doctor speak of jealousy I cannot understand it. I remember some time ago, about two years, there was another doctor gave me a roast in my neighborhood, a man that is only two or three blocks from my office and the first thing I thought of was to get him into the society. I went to his office and got his application and we took him into the society. Though the man don't know it, I know just what he said and all about it. It didn't hurt me a particle, I paid no attention to it whatever I took him into the society for the purpose of getting even with him in that manner but I have never been able to do so because he has never been there. He cast a reflection on my intellect—I don't know what he meant—an obsession probably. My object was to get him into a debate because if he had cast a reflection on my intellect I was willing to put it up against his. And the next thing I thought of was I might meet that man in a case but I didn't, and I think the man is a pretty good friend of mine today, I don't know. I would not tell on him for anything on earth and as far as jealousy is concerned, I don't know what it means, but our district is in a right flourishing condition. We don't get out all the members each meeting, and I expect you people in the smaller cities have a larger membership attending than we do. Sometimes we have a larger number and sometimes don't have so large a gathering. I presume you people in the smaller places have a more steady crowd than we have.

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Councillors from 5th, 6th and 8th Districts were not present and no reports from these districts were given.



## REPORTS OF STANDING COMMITTEES.

The Committee to prepare Bill on Vital Statistics made the following report:

Kansas City, Kansas, May 7th, 1908.

## KANSAS STATE MEDICAL SOCIETY:

MR. CHAIRMAN:—Your Committee on Vital Statistics, to which was referred the matter of legislation respecting the immediate registration of all births and deaths throughout the state of Kansas by means of certificates of births and deaths, etc., begs leave to submit the following report:

The Committee considers such legislation as of the greatest importance, more so the need of a suitable system of accurate registration of vital and mortuary statistics.

In an enlightened community there live but few people of mature age whose birth, marriage or death does not some time become a matter for the cognizance and consideration of legal authorities. The attainment of majority with its rights and duties, the fact and date of wedlock, the inheritance or conveyance of property, parentage and nationality, place, date and cause of death and interment, and many other questions of a sociological, economic, sanitary, or even historical character, often assume much importance with reference to many of our citizens.

While we have no vital statistics for the United States as a whole, yet we have returns of deaths from about sixteen states having effective laws and from certain cities in non-registration states, where there has been effective local registration. It is stated by the bureau of Census that only about one-half or our entire population is represented by mortality statistics, while in some states inadequate or ineffective laws for this purpose now exist.

The immediate registration of births and deaths under proper registration methods acts as a deterrent of crime; furthermore, experience has shown that in those states having no system of registration many of the citizens are deprived of their legal rights or are enabled to deprive their fellows of their legal rights.

Vital statistics are the measure by which we gauge and weigh with approximate exactness the movement of our population, whether increasing or diminishing, the mortality from different causes, the effect of seasons, climate, occupation, locality, and other environments on which the health of individuals and communities depend.

It is the duty of every member of the Kansas State Medical Society to help advance the day of reliable vital statistics in this state. We must encourage and help the State authorities, chiefly the members of the State Board of Health who are now advocating the adoption of effective legislation. On the other hand we must discourage the adoption of measures of which experience has shown to be wholly inadequate for the purpose for which they are proposed.

To accomplish this purpose it will be necessary that the State Medical Society and all of its members publicly and privately, at home and everywhere, use their influence unceasingly until finally the system will be adopted and this record of life and death be made complete throughout our state.

Your committee has secured from nearly all the so-called "registration states and cities" the laws providing for the immediate registration of all births and deaths and has carefully noted the progress and the interest of the movement for an accurate registration of vital statistics. Experience has shown that it is far better to adopt methods that have been tested and uniformly found to give good results. In order to accomplish this the sanitary authorities and the medical profession must show a vigorous interest in the matter and help to educate the public and the members of our legislature as to the essential provisions of an effective registration law.

The National Legislation Council of the American Medical Association, at its annual conference held in Chicago last December, submitted a draft of a proposed bill on Registration of Vital Statistics for the adoption of the various states, a copy of which your committee herewith encloses.

This proposed bill has been submitted to the Committee of the American Public Health Association and the United States Census Bureau in Washington, D. C. The former Committee has recommended the bill to its Association for adoption and the Census Bureau has approved it. A few minor

changes in regard to the payment of fees and the time of report, etc., will probably come up at the Chicago meeting next month. Also a sufficient amount of money should be appropriated by the Legislature for the general running expenses of the office of the State Registrar, which should be made a part of the bill.

Your committee therefore recommends the hearty co-operation with American Public Health Association, the American Medical Association and the Census Bureau of Vital Statistics, which so far have afforded a safe and efficient guide for legislation and have greatly aided in the extension of the registration area.

We further recommend, that the Vital Statistics act as herewith enclosed be adopted by this society and then presented to our next Legislature and urging its prompt passage.

EARNEST J. LUTZ,  
B. M. BARNETT,  
Com. on Vital Statistics.

#### AN ACT.

To provide for the immediate registration of all births and deaths throughout the State of Kansas, by means of certificates of births and deaths, and burial or removal permits; requiring prompt returns to the central bureau of vital statistics at the capital of the state, as required to be established by the State Board of Health, and to insure the thorough organization and efficiency of the registration of vital statistics throughout the state, and providing certain penalties.

Be it enacted by the Legislature of the State of Kansas:

Section 1—That it shall be the duty of the State Board of Health to have charge of the State system of registration of births and deaths; to prepare the necessary methods, forms and blanks for obtaining and preserving such records and to insure the faithful registration of the same in the townships, cities, counties and in the central bureau of vital statistics at the capital of the State. The said board shall be charged with the uniform and thorough enforcement of the law throughout the state, and shall from time to time promulgate any additional forms and amendments that may be necessary for this purpose.

Section 2—That the Secretary of the State Board of Health shall have general supervision over the central bureau of vital statistics, which is hereby authorized to be established by said board, and which shall be under the immediate direction of the state registrar of vital statistics, whom the State Board of Health shall appoint within thirty days after the taking effect of this law, and who shall be a medical practitioner of not less than five years' practice in his profession, and a competent vital statistician. The term of appointment of state registrar of vital statistics shall be four years, beginning with the first day of January of the year in which this act shall take effect, and any vacancy occurring in the office of state registrar of vital statistics shall be filled by appointment of the State Board of Health. The state registrar of vital statistics shall receive an annual salary at the rate of two thousand dollars from the date of his appointment. The State Board of Health shall appoint an assistant state registrar, who shall be an expert statistician, at an annual salary of eighteen hundred dollars, and shall also provide for a chief clerk at a salary of twelve hundred dollars a year, two stenographers at a salary of nine hundred dollars each a year and for such other clerical and other assistance as may be necessary for the purposes of this act, who shall serve during the pleasure of the board, and may fix the compensation of the persons thus employed within the amount appropriated therefor by the legislature. Suitable apartments shall be provided by the custodian of the capitol for the bureau of vital statistics in the state capitol at Topeka, Kansas, which shall be properly equipped with fireproof vault and filing cases for the permanent and safe preservation of all official records made and returned under this act.

Section 3—That for the purposes of this act the state shall be divided into registration districts as follows: Each city and incorporated town shall constitute a primary registration district; and for that portion of each county outside of the cities and incorporated towns therein, the State Board of Health shall define and designate the boundaries of a sufficient number of

rural registration districts, which it may change from time to time as may be necessary for convenience and completeness of registration.

Section 4—That within ninety days after the taking effect of this act, or as soon thereafter as possible, the State Board of Health shall appoint a local registrar of vital statistics for each registration district in the state. The term of office of local registrars, appointed by said board shall be for four years beginning with the first day of January of the year in which this act shall take effect, and their successors shall be appointed at least ten days before the expiration of their terms of office.

Any local registrar appointed by said board who fails or neglects to efficiently discharge the duties of his office as laid down in this act, or who fails to make prompt and complete return of births and deaths, as required hereby, shall be forthwith removed from his office by the State Board of Health, and his successor appointed, in addition to any other penalties that may be imposed, under other sections of this act, for failure or neglect to perform his duty.

Each local registrar appointed by said board shall, immediately upon his acceptance of appointment as such, appoint a deputy, whose duty it shall be to act in his stead in case of absence, illness or disability, and who shall accept such an appointment in writing, and who shall be subject to all rules and regulations governing the action of local registrars. And when it may appear necessary for the convenience of the people in any township, the local registrar is hereby authorized, with the approval of the state registrar to appoint one or more suitable persons to act as sub-registrars, who shall be authorized to receive certificates, and to issue burial or removal permits in and for such portions of the township as may be designated; and each sub-registrar shall note, over his signature, the date on which each certificate was filed and forward all certificates to the registrar of the township within ten days, and in all cases before the third day of the following month; provided, that all sub-registrar shall be subject to the supervision and control of the state registrar, and may be by him removed for neglect or failure to perform their duties in accordance with the provisions of this act or the rules and regulations of the state registrar, and they shall be liable to the same penalties for neglect of duties as the local registrars.

Section 5—That the body of any person whose death occurs in the state shall not be interred, deposited in a vault or tomb, cremated or otherwise disposed of, or removed from or into any registration district until a permit for burial, removal or other disposition shall have been properly issued by the registrar of the registration district in which the death occurs. And no such burial or removal permit shall be issued by any registrar until a complete and satisfactory certificate and return of the death has been filed with him as hereinafter provided; provided, that a transit permit issued in accordance with the law and health regulation of the place where the death occurred, whether in Kansas or outside the state, may be accepted by the local registrar of the district where the body is to be interred or otherwise finally disposed of, as a basis upon which he shall issue a local burial permit, in the same way as a death occurred in his district, but shall plainly enter upon the face of the copy of the record which he shall make for return to the state registrar the fact that it was the body shipped in for interment, and give the actual place of death. But when a body is removed from a district into an adjacent or near-by district for interment, not requiring the use of a common carrier or the issue of a transit permit, then the registrar's removal permit from the district where death occurred may be accepted as authority for burial.

Section 6—That still born children or those dead at birth shall be registered as births and also as deaths, and a certificate of both the birth and death shall be filed with the local registrar, in the usual form and manner, the certificate of birth to contain, in place of the name of the child, the word "still-birth." The medical certificate of the cause of death shall be signed by the attending physician, if any, and shall state the cause of death as "stillborn," with the cause of the stillbirth, if known, whether a premature birth, and if born prematurely, the period of uterogestation, in months, if known; and a burial or removal permit in the usual form shall be required. Midwives shall not sign certificates of death for stillborn children; but such cases, and stillbirths occurring without attendance of either physician or midwife, shall



be treated as deaths without medical attendance, as provided for in Section 8 of this act.

Section 7—That the certificate of death shall contain the following items:

- (1) Place of death, including state, county, township, or city. If in a city, the ward, street and house number. If in a hospital or other institution, the name of the same to be given instead of the street and house number. If in an industrial camp, the name to be given.
- (2) Full name of decedent. If an unnamed child, the surname preceded by "unnamed."
- (3) Sex.
- (4) Color or race—as white, black, (negro or negro descend), Indian, Chinese, Japanese, or other.
- (5) Conjugal condition—as single, married, widower or divorced.
- (6) Date of birth, including the year, month and day.
- (7) Age, in years, months, and days.
- (8) Place of birth; city or town and state or foreign country.
- (9) Name of father.
- (10) Birthplace of father; city or town and state or foreign country.
- (11) Maiden name of mother.
- (12) Birthplace of mother; city or town and state or foreign country.
- (13) Occupation. The occupation to be reported of any person who had any remunerative employment; women as well as men.
- (14) How long a resident of city or county.
- (15) Signature and address of informant.
- (16) Date of death, including the year, month, and day.
- (17) Statement of medical attendant on decedent, fact and time of death, including the time last seen alive.
- (18) Cause of death, including the primary and contributory causes or complications, if any, and duration of each.
- (19) Signature and address of physician or official making the medical certificate.
- (20) Special information concerning deaths in hospitals and institutions and of any persons dying away from home, including the former or usual residence; length of time at place of death, and place where the disease was contracted.
- (21) Place of burial or removal.
- (22) Date of burial or removal.
- (23) Signature and address of undertaker.
- (24) Official signature of registrar, with the date when certificate was filed, and registered number.

The personal and statistical particulars (Items 1 to 13) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or the sequence of causes resulting in the death, giving the primary and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar shall be returned to the physician for correction and definition. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and, if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal. And in cases of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required under this head (Item 20), and shall state where, in his opinion, the disease was contracted.

Section 8—That in case of any death occurring without medical attendance, it shall be the duty of the undertaker to notify the registrar of such



death, and when so notified the registrar shall inform the local health officer and refer the case to him for immediate investigation and certification, prior to issuing the permit; provided, that when the local health officer is not a qualified physician, or when there is no such official, and in such cases only, the registrar is authorized to make the certificate and return from the statement of relatives or other persons having adequate knowledge of the facts; provided further, that if the circumstances of the case render it probable that the death was caused by unlawful or suspicious means, the registrar shall then refer the case to the coroner for his investigation and certification. And any coroner whose duty it is to hold an inquest on the body of any deceased person, and to make the certificate of death required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death; and, if from external causes or violences, whether (probably) accidental, suicidal, or homicidal as determined by the inquest; and shall, in either case, furnish such information as may be required by the state registrar to properly classify the death.

Section 9—That the undertaker, or person acting as undertaker, shall be responsible for obtaining and filing the certificate of death with the registrar, and securing a burial or removal permit, prior to any disposition of the body. He shall obtain the personal and statistical particulars required from the person best qualified to supply them, over the signature and address of his informant. He shall then present the certificate to the attending physician, if any, or to the health officer or coroner, as directed by the registrar, for the medical certificate of the cause of death and other particulars necessary to complete the record, as specified in Section 8. And he shall then state the facts required relative to the date and place of burial, over his signature and with his address, and present the completed certificate to the registrar, within the time limit, if any, designated by the local board of health for the issuance of a burial or removal permit. The undertaker shall deliver the burial permit to the sexton, or person in charge of the burial before interring the body; or shall attach the transit permit to the box containing the corpse, when shipped by any transportation company; said permit to accompany the corpse to its destination where, if within the state of Kansas, it shall be taken up by the local registrar of the district in which interment is made, who shall issue a burial permit thereon.

Section 10—That if the interment, or other disposition of the body is to be made within the state, the wording of the burial permit may be limited to a statement by the registrar, and over his signature that a satisfactory certificate of death having been filed with him, as required by law, permission is granted to inter, remove, or otherwise dispose of the deceased, stating the name, age, sex, cause of death, and other necessary details upon the form prescribed by the state registrar.

Section 11—That no sexton or person in charge of any premises in which interments are made shall inter or permit the interment or other disposition of any body unless it is accompanied by a burial, removal or transit permit, as herein provided. And each sexton, or person in charge of any burial ground, shall indorse upon the permit the date of interment, over his signature, and shall return all permits so indorsed to the local registrar of his district within ten days from the date of interment, or within the time fixed by the local board of health. He shall also keep a record of all interments made in the premises under his charge, stating the name of the deceased person, place of death, date of burial, the name and address of the undertaker; which record shall at all times be open to public inspection.

Section 12—That all births that occur in the state shall be immediately registered in the districts in which they occur, as hereinafter provided.

Section 13.—That it shall be the duty of the attending physician or midwife to file a certificate of birth, properly and completely filled out, giving all the particulars required by this act, with the local registrar of the district in which the birth occurred, within ten days after the date of birth. And if there be no attending physician or midwife, then it shall be the duty of the father or mother of the child, householder or owner of the premises, manager or superintendent of public or private institution in which the birth occurred, to notify the local registrar, within ten days after the birth, of the fact of such a birth having occurred. It shall then, in such case, be the duty of the

local registrar to secure the necessary information and signature to make a proper certificate of birth.

Section 14.—That the certificate of birth shall contain the following items:

( 1 ) Place of birth, including state, county, township or town, village or city. If in a city, the ward, street, and house number; if in a hospital or other institution, the name of the same to be given, instead of the street and house number.

( 2 ) Full name of child. If the child dies without a name, before the certificate is filed, enter the words, "died unnamed." If the living child has not yet been named at the date of filing certificate of birth, the space for "full name of child" is to be left blank, to be filled out subsequently by a supplemental report, as hereinafter provided.

( 3 ) Sex of child.

( 4 ) Whether a twin, triplet, or other plural birth. A separate certificate shall be required for each child in case of plural birth, giving number of child in order of birth.

( 5 ) Whether legitimate or illegitimate.

( 6 ) Full name of father.

( 7 ) Residence of father.

( 8 ) Color or race of father.

( 9 ) Birthplace of father.

(10) Age of father at last birthday, in years.

(11) Occupation of father.

(12) Maiden name of mother.

(13) Residence of mother.

(14) Color or race of mother.

(15) Birthplace of mother.

(16) Age of mother at last birthday, in years.

(17) Occupation of mother.

(18) Number of child of this mother, and number of children of this mother now living.

(19) Born at full term.

(20) The certificate of attending physician or midwife as to attendance at birth, including statement of year, month, day and hour of birth, and whether the child was alive or dead at birth. This certificate shall be signed by the attending physician or midwife, with date of signature and address; there is no physician or midwife in attendance, then the father or mother of the child, householder or owner of the premises, or manager or superintendent of public or private institution, or other competent person, whose duty it shall be to notify the local registrar of such a birth, as required by Section 13 of this act.

(21) Exact date of filing in office of local registrar, attested by his official signature, and registered number of birth as hereinafter provided.

All certificates, either of birth or death, shall be written legibly, in unfading black ink, and no certificate shall be held to be complete and correct that does not supply all the items of information called for herein, or satisfactorily account for their omission.

Section 15.—That when any certificate of birth of a living child is presented without statement of the given name, then the local registrar shall make out and deliver to the informant a special blank for the supplemental report of the given name of the child, which shall be filled out as directed, and returned to the registrar as soon as the child shall be named. The original certificate of birth shall not be considered complete until the supplemental report is filed or the blank returned with the statement, "died unnamed."

Section 16.—That every physician, midwife and undertaker shall, without delay, register his or her name, address and occupation with the local registrar of the district in which he or she resides, or may hereafter establish a residence; and shall thereupon be supplied by the local registrar with a copy of this act, together with such rules and regulations as may be prepared by the state registrar relative to its enforcement. Within thirty days after the close of each calendar year each local registrar shall make a return to the state registrar of all physicians, midwives or undertakers who have been

registered in his district during the whole or any part of the preceding calendar year; provided, that no fee or other compensation shall be charged by local registrars to physicians, midwives or undertakers for registering their names under this section or making returns thereof to the state registrar.

Section 17.—That all superintendents or managers or other persons in charge of hospitals, almshouses, lying-in or other institutions, public or private, to which persons resort for treatment of disease, confinement, or are committed by process of law, are hereby required to make a record of all the personal and statistical particulars relative to the inmates of their institutions at the date of approval of this act, that are required in the form of the certificate provided for by this act, as directed by the state registrar; and thereafter such record shall be, by them, made for all future inmates at the time of their admission. And in case of persons admitted or committed for medical treatment of disease, the physician in charge shall specify for entry in the record, the nature of the disease, and where, in his opinion, it was contracted. The personal particulars and information required by this section shall be obtained from the individual himself if it is practicable to do so; and when they cannot be so obtained, they shall be secured in as complete a manner as possible from the relatives, friends, or other persons acquainted with the facts.

Section 18.—That the State Registrar shall prepare and print and supply to all registrars all blanks and forms used in registering, recording and preserving the returns, or in otherwise carrying out the purposes of this act; and shall prepare and issue such detailed instructions as may be required to secure the uniform observance of its provisions and the maintenance of a perfect system of registration. And no other blanks shall be used than those supplied by the state registrar. He shall carefully examine the certificates received monthly from the local registrars, and if any such are incomplete or unsatisfactory he shall require such further information to be furnished as may be necessary to make the record complete and satisfactory. And all physicians, midwives, informants or undertakers connected with any case, and all other persons having knowledge of the facts, are hereby required to furnish such information as they may possess regarding any birth or death upon demand of the state registrar, in person, by mail, or through the local registrar. He shall further arrange, bind, and permanently preserve the certificates in a systematic manner, and shall prepare and maintain a comprehensive and continuous card index of all births and deaths registered; the cards to show the name of the child or deceased, place and date of birth or death, number of certificate, and the volume in which it is contained. He shall inform all registrars what diseases are to be considered as infectious, contagious or communicable and dangerous to the public health, as decided by the State Board of Health, in order that when deaths occur from such diseases proper precautions may be taken to prevent the spreading of dangerous disease.

Section 19.—That it shall be the duty of the local registrar to supply blank forms of certificates to such persons as require them. And he shall carefully examine each certificate of birth or death when presented for record, to see that it has been made out in accordance with the provisions of this act and the instructions of the state registrar; and if any certificate of death is incomplete or unsatisfactory, it shall be his duty to call attention to the defects in the return, and to withhold issuing the burial or removal permit until they are corrected. If the certificate of death is properly executed and complete, he shall then issue a burial or removal permit to the undertaker; provided, that in case the death occurred from some disease that is held by the State Board of Health to be infectious, contagious or communicable and dangerous to the public health, no permit for the removal or other disposition of the body shall be granted by the registrar, except under such conditions as may be prescribed by the State Board of Health. If a certificate of birth is incomplete, he shall immediately notify the informant, and require him to supply the missing items if they can be obtained. He shall then number consecutively the certificates of birth and death, in two separate series, beginning with the number "one" for the first birth and the first death in each calendar year, and sign his name as registrar in attest of the date of filing in his office. He shall also make a complete and accurate



copy of each birth and death certificate registered by him, upon a form identical with the original certificate, to be filled and permanently preserved in his office as the local record of such death, in such manner as directed by the state registrar. And he shall, on the fifth day of each month, transmit to the state registrar all original certificates registered by him during the preceding month. And if no births or deaths occurred in any month, he shall, on the fifth day of the following month report that fact to the state registrar, on a card provided for this purpose.

Section 20.—That each local registrar shall be entitled to be paid the sum of twenty-five cents for each birth and each death certificate properly and completely made out and registered with him, and correctly copies and duly returned by him to the state registrar, as required by this act. And in case no births or deaths were registered during any month, the local registrar shall be entitled to be paid the sum of twenty-five cents for each report to that effect, promptly made in accordance with this act. All amounts payable to registrars under provisions of this section shall be paid by the treasurer of the county in which the registration districts are located, upon certification by the state registrar. And the state registrar shall annually certify to the treasurers of the several counties the number of births and deaths registered, with the names of the local registrars and the amounts due each at the rates fixed herein.

Section 21.—That the state registrar shall, upon request, furnish any applicant a certified copy of the record of any birth or death registered under provisions of this act for the making and certification of which he shall be entitled to a fee of fifty cents, to be paid by the applicant. And any such copy of the record of a birth or death, when properly certified by the state registrar to be a true copy thereof, shall be prima facie evidence in all courts and places of the facts therein stated. For any search of the files and records when no certified copy is made, the state registrar shall be entitled to a fee of fifty cents for each hour or fractional hour of time of search, to be paid by the applicant. And the state registrar shall keep a true and correct account of all fees by him received under these provisions, and turn the same over to the state treasurer.

Section 22.—That if any physician who was in medical attendance upon any deceased person at the time of death shall neglect or refuse to make out and deliver to the undertaker, sexton, or other person in charge of the interment, removal, or other disposition of the body, upon request, the medical certificate of the cause of death, hereinbefore provided for, he shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than five dollars nor more than fifty dollars. And if any physician shall knowingly make a false certification of the cause of death, in any case, he shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be fined not less than fifty dollars nor more than two hundred dollars.

And any physician or midwife in attendance upon a case of confinement or any other person charged with the responsibility for reporting births, in the order named in Section 13 of this act, who shall neglect or refuse to file a proper certificate of birth with the local registrar, within the time required by this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than five dollars nor more than fifty dollars.

And if any undertaker, sexton, or other person acting as undertaker, shall inter, remove, or otherwise dispose of the body of any deceased person, without having received a burial or removal permit as herein provided, he shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than twenty dollars nor more than one hundred dollars.

And any registrar, deputy registrar, or sub-registrar who shall neglect or fail to enforce the provisions of this act in his district, or shall neglect or refuse to perform any of the duties imposed upon him by this act or by the instructions and directions of the state registrar, shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than ten dollars nor more than one hundred dollars.

And any person who shall willfully alter any certificate of birth or death or the copy of any certificate of birth or death, on file in the office of the local registrar, shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than ten dollars nor more than one hundred



dollars, or be imprisoned in the county jail not exceeding sixty days, or suffer both fine and imprisonment, in the discretion of the court.

And any person or persons who shall violate any of the provisions of this act, or who shall willfully neglect or refuse to perform any duties imposed upon them by the provisions of this act, or shall furnish false information to a physician, undertaker, midwife, or informant, for the purpose of making incorrect certification of births or deaths, shall be deemed guilty of a misdemeanor and upon conviction thereof, shall be fined not less than five dollars nor more than one hundred dollars.

And any transportation company or common carrier transporting or carrying, or accepting through its agents or employes for transportation or carriage, the body of any deceased person, without an accompanying permit issued in accordance with the provisions of this act, shall be deemed guilty of a misdemeanor, and upon conviction thereof, shall be fined not less than fifty dollars nor more than two hundred dollars; provided, that in case the death occurred outside the state and the body is accompanied by a certificate of death, burial or removal, or transit permit issued in accordance with the law or board of health regulations in force when the death occurred, such death certificate, burial or removal or transit permit may be held to authorize the transportation or carriage of the body into or through the state.

Section 23.—That local registrars are hereby charged with the strict and thorough enforcement of the provisions of this act in their districts, under the supervision and direction of the state registrar. And they shall make an immediate report to the state registrar of any violation of this law coming to their notice by observation or upon complaint if any person, or otherwise. The state registrar is hereby charged with the thorough and efficient execution of the provisions of this act in every part of the state, and with supervisory power over local registrars, to the end that all the requirements shall be uniformly complied with. He shall have authority to investigate cases of irregularity or violation of law, personally or by accredited representative, and all registrars shall aid him, upon request in such investigations. When he shall deem it necessary, he shall report cases of violation of any of the provisions of this act to the prosecuting attorney or official of the proper county or municipality, with a statement of the facts and circumstances; and when any such case is reported to them by the state registrar, all prosecuting attorneys or officials acting in such capacity, shall forthwith initiate and promptly follow up the necessary court proceedings against the parties responsible for the alleged violations of the law. And upon request of the state registrar, the attorney-general shall likewise assist in the enforcement of the provisions of this act.

Section 24.—That this act shall be in force and effect on and after its publication in the statute books.

#### COMMITTEE ON SCIENTIFIC WORK.

C. S. HUFFMAN, Chairman.

The program of this meeting is the result of our work, and when we get through with this session you probably will have a better idea as to the results of the work.

#### COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

C. C. GODDARD, Chairman.

C. C. GODDARD—The committee as a committee have never had any meeting for the simple reason that they have not been called together, I guess. That wasn't what I started to say but as there was no probability of getting anything before the short session of the legislature, they knew of no legislation particularly they could get, but as chairman of that committee I attended the meeting of Vital Statistics in Chicago on invitation of that society, and was there with Dr. Lutz, and the meeting of that society is more important than I had any idea of, and the war cry there was vital statistics. They want you to all register yourself when you are born and how old you are. They are going to do that in Ohio, they are going to reg-

ister everybody, was Dr. Reeds claim, in order to get a starter; and in Vital Statistics, so far as births are concerned, Kansas is not on their map, and there are only about three states that are on the map, and the talk and the urging was to get the State Societies to appeal to the people belonging to these societies the importance of Vital Statistics, and the question came up about registering births, who should do it, and whether they should be paid for it and everything else, and they quit about where they started, not having any satisfactory solution how it would be done, whether the doctors should do it or the parents should do it or whether they should have some special health officer that should do it. On account of the laws of the states, especially Kansas, there is nothing that compels it, so the doctor gets in trouble if he doesn't do it, but there ought to be some legislation along that line making it compulsory more than it is now. That is about the only thing I could have to report. I did have some letters from different doctors about what legislation they wanted. One doctor wanted me to get some legislation fixed so he could be appointed in charge of some state home—that was the gist of his letter, that he be made eligible to that appointment, but I could not see any particular good it was going to do the State Society nor its members if I got him appointed to that lucrative position. But although we notified through the Journal to get pointers on all the legislation required, that was the gist of everything we did get. That was the only thing we heard from.

#### COMMITTEE ON ARRANGEMENTS.

F. H. MARTIN, Chairman.

F. H. MARTIN—I have not any written report. I will say, you can see we have a hall and have carried out as nearly as possible the ideas we got from the program and from the secretary. Dr. Mitchell really is the proper one to make the report. While I am the general chairman of the Committee on Arrangements, Dr. Mitchell has virtually taken that place by reason of being secretary. We really have laid no plans except as you have laid them, except as to the banquet. It will be held Thursday night—I understand there is something before the banquet in this hall, that I know nothing about, but the banquet will be held at 9:30 in Masonic hall, four or five doors below. There has also been a committee of the wives, and so forth, of the physicians appointed, and the ladies, wives, daughters, sweet hearts, etc., of the visiting physicians will be entertained on Thursday afternoon at 4 o'clock. Announcements will be made later with reference to that. We had arranged a trolley ride but I understand that will not be favored. It however can be arranged for afterwards.

#### UNFINISHED BUSINESS.

The secretary read a letter from Dr. Frederick Green, Asst. Secretary of the American Medical Association, in regard to dividing the American Medical Association up into District Associations, but no action was taken on it by the society.

Drs. P. S. Mitchell and R. A. Roberts were appointed a committee to audit the books of the Society.

There being no further business, on motion duly seconded and carried, the House of Delegates adjourned.

#### MEETING OF HOUSE OF DELEGATES.

Friday morning, May 8th, 1908, in Elk's Hall.

House of Delegates called to order by President J. E. Sawteli, C. S. Huffman, Secretary.

Upon roll call of delegates a quorum was found to be present.

#### ELECTION OF OFFICERS.

The following officers were elected for the ensuing year:  
 President, Dr. C. C. Goddard, Leavenworth.  
 1st Vice-President, Dr. E. E. Liggett, Oswego.

2nd Vice-President, Dr. G. W. Goss, Sedan.  
 3rd Vice-President, Dr. B. M. Barnett, Rosedale.  
 Secretary, Dr. C. S. Huffman, Columbus, (term of three years).  
 Treasurer, Dr. L. H. Munn, Topeka.  
 Librarian, Dr. S. G. Stewart, Topeka.

Delegates to A. M. A.:

Dr. J. E. Sawtell, Kansas City, (two years).  
 Dr. G. W. Tooley, Washington, (one year).

Councillors—Three years each:

1st District—Chas. W. Reynolds, Holton.  
 4th District—Dr. O. J. Furst, Peabody.  
 6th District—J. A. Dillon, Larned.

The report of the Committee on Vital Statistics was presented, and on motion, the reading of same was dispensed with and it was ordered printed in the Journal.

The following resolutions were read and adopted as read:

RESOLUTION NO. 1:

Resolved, That the Editor of the Kansas State Medical Journal be instructed to print 500 extra copies of the number containing the Vital Statistic Act, to be used for the promulgation of said Act among physicians and representatives.

RESOLUTION NO. 2:

Resolution adopted and sent by telegraph to Dr. Chas. A. L. Reed.

The Kansas State Medical Society, in Annual Session assembled, unanimously express their approbation of your candidacy as United States Senator from Ohio. The great interest you have displayed in the matters of Public Health as President of the American Medical Association, and as Chairman of the Committee on Medical Legislation of that great body, together with the personal sacrifice of your lucrative practice, should commend you to the people of your state for political preferment regardless of party.

RESOLUTION NO. 3:

Resolved, That to the end of alleviating suffering, and protecting the healthy from the danger of contagion, The Kansas Medical Society, now assembled, recommend and urge the next Legislature of Kansas to build and equip a sanitarium for the care and treatment of the indigent tubercular citizens of the State.

RESOLUTION NO. 4:

To his Excellency, Governor E. W. Hoch:—We, the Kansas State Medical Society, representing the registered physicians throughout the State, realizing our duties as guardians of the public health and welfare, acting on your request to select men to fill the vacancies to be created in the State Board of Medical Examiners, of whose qualifications we should best be able to judge, do hereby offer the names of Dr. G. L. Millington, of Wellington, Sumner County, and Dr. E. R. Keith, of Lawrence, Douglas County, as medical men eminently fitted for those positions, and imbued with a high sense of personal integrity.

RESOLUTION NO. 5:

Inasmuch as we have listened with pleasure to a detailed statement, by Dr. Crumrine, of the work of the Kansas State Board of Health, during the last year along the line of the preservation of the public health, now, therefore, be it

Resolved, By The Kansas State Medical Society, now in session, that we are in hearty accord with the work done and outlined to do, and commend the Board for what it has accomplished, and pledge it our hearty support and co-operation along the same lines in the future.

## RESOLUTION NO. 6:

The establishment of a sound rational physique is of more importance to our Nation than the establishment of a sound National finance; when the people commence to decay physically it marks the beginning of the downfall of our nation.

Believing those principles to be true, we endorse the efforts of our Committee on Medical Legislation and recommend that steps be taken in every possible way to secure the enactment of a Bill whereby all matters relating to the preservation and improvement of public health and Sanitation be placed under the control of a single National Health Department into which shall be merged all existing National Public Health Agencies vested with adequate power and ample financial support so as to give the strongest possible federal control over all National Public Health interests.

## RESOLUTION No. 7.

Whereas, Physical well being is the foundation of civil virtue,

Whereas, Publicity and accurate knowledge is necessary for the exercise of good government,

Whereas, Kansas is about to adopt a uniform system of municipal accounts through its Tax Commissioners,

Whereas, vital statistics are invaluable for the municipality as well as the State, be it

Resolved, That the Legislative Committee use every effort to have incorporated in this system, means for ascertaining, accurately, recording disseminating and making public such information for the education of the people in those measures that concern the Public Health.

Moved and seconded that the Society send the Secretary and Editor to the meeting of the A. M. A., as representatives to the Association of State Secretaries and Editors respectively, and that the Society pay actual expenses. Motion carried.

Invitations were extended by Topeka, Wichita, Emporia, and Kansas City to the Society to meet next year.

Upon vote of the House of Delegates Emporia was selected.

Moved and seconded that the House of Delegates adjourn.

Motion carried.

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The scientific part of the program began Wednesday morning, May 6, and lasted until noon Friday, May 7. The papers and discussions will be published in the Journal during the year.

CHAS. S. HUFFMAN, Secretary.

The President, Dr. C. C. Goddard, made the following appointment: Legislative Committee—J. E. Sawtell, chairman, Kansas City; M. T. Sudler, Lawrence, and Chas. S. Huffman, Columbus.



The Tri-County Medical Society of Kansas, met in the office of Drs. Higginbotham & Jones, Tuesday, June 2nd, and elected the following permanent officers for the ensuing year: Dr. Leslie, of Meade County, President; Dr. Gaston, of Meade County, Vice-President; Dr. Higginbotham, of Seward County, Sec. and Treas. Owing to the close connection of the east and west bound trains the session was necessarily brief. The next monthly meeting will be held at Meade, Kans., Tuesday, July 7th. We hope to have a full attendance. THOS. HIGGINBOTHAM, M. D., Sec.



The Kansas Medical Society will hold its next meeting at Emporia, May, 1909.

The Wyandotte County Medical Society held its last meeting before the summer vacation, June 15th. The next regular meeting will be held October 5th.



The American Medical Association will hold its next meeting at Atlantic City, June, 1909.



The Eclectic Medical Association of America held its annual meeting at Kansas City, Mo., June 16th, 17th, and 18th.



#### KANSAS MEDICAL COLLEGE, TOPEKA, NOTES.

Dr. W. S. Winter, Jr., of the class 1908, has located in Port Arthur, Texas. He is connected with the Lake View Hospital at that place.



Dr. Samuel Adams, of the class 1908, of Danville, Ill., is visiting in Topeka. He is assistant surgeon, under Dr. D. C. Jones, formerly of Topeka, in the Danville U. S. Soldiers' Home.



Dr. Merrill Mills is visiting his parents in Topeka. He is an interne in the Roosevelt Hospital, New York City.



Dr. H. D. Riordan, of the class 1908, has located at Delphos, Kansas.



Dr. F. J. Isenberger, of the class 1908, has located at Natoma, Kansas.



Governor Hoch has appointed Dr. T. L. Millington, of Wellington, and Dr. E. B. Packer, of Osage, as members of the Kansas Board of Medical Examination and Registration. They are to take the places of Dr. D. P. Cook, of Clay Center, and Dr. W. F. Flack, of Longton. At the last meeting the board elected Dr. F. P. Hatfield, of Olathe, President, and Dr. R. A. Light, of Chanute, Secretary. The board held its meeting for examination of candidates at Kansas City, Kansas, June 12th and 13th.

# THE JOURNAL

## OF THE

# Kansas Medical Society.

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### PROSTATIC HYPERTROPHY.

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DR. L. H. MUNN, Topeka, Kansas.

Read before the Kansas Medical Society, at Iola, May 7, 1908.

I have selected this text as hypertrophy. It belongs to the type of trouble which is surgically, the most interesting and in which the greatest number of errors in diagnosis are made. The subject is not a new one; from the earliest times medical men have considered it. It selects men who have passed the meridian of life, without any consideration for their former health and activity.

You I trust, will pardon me, if I refer to the fact that the prostate is a mixed organ; a muscular and glandular body, quite  $\frac{3}{4}$  of it being muscular, of the unstriped kind, and  $\frac{1}{4}$  glandular. Its shape and size is like a horse-chestnut, it weighs about 275 grains. It is situated a little below the symphysis pubis and only a short distance from the anus. It surrounds the posterior urethra and neck of the bladder.

It is held in place by the pubo prostatic ligaments and the anterior fibers of the levator ani muscles. Between the prostate and rectum is a quantity of loose connective tissue and the prostatic plexus of veins. Normally the prostate consists of two lateral lobes, separated by a depression and fissures; additional lobes or irregularities are the result of changes coming from age, disease or injury.

It has a dense fibrous capsule, reflections of which pass into the substance of the organ. The vacuine glands are covered with columnar epithelium. The functions of the prostate has

caused much speculation. The concensus of opinion, is that it is purely a sexual organ, and that any other use, if it has any is purely secondary.

Physiologically through its muscular endowment, the prostate controls the ejaculatory ducts. Just inside of its mucous coat is a system of nerves, very peculiar in their origin and arrangement, the function and action of which in an unsolved problem.

The glandular features of this organ is very important. Its secretion is distinctly antiseptic for the spermatic fluid. It offers food and protection to the spermatozoa.

Why should an organ that is so absolutely indispensable, and without which the race would end, be the source of so much trouble to such a large percentage of old fellows, and to some of us who do not feel as old as actual evidence would prove?

After spending some time in looking up the pathology, I am of the opinion that there is a little known and that little is disputed by the different authorities. They all seem to agree that it is a chronic, noninflammatory hyperplasia, affecting both the glandular and muscular tissues. Arteriol sclerosis has been thought to be the cause by Guyon and as ably disputed by Cooper and Motz. The analogy between prostatic hypertrophy and the fibroma theory of Thompson, has faded under the light of modern research.

White and Martin's theory, that there was some relation between it and the testicles, is at this time not considered.

Personally I incline to bacteria as the original cause of the trouble, and in my opinion it depends upon an inflammatory origin, and in the majority of instances the cause is the gonococci.

A diagnosis of the abstract fact of hypertrophy is easy. The refinement necessary to actually measure and determine its precise geography, while it is interesting from a scientific standpoint, requires special instruments and skill and these are not always at our command.

The damage, that the prostate can do, does not depend entirely upon its size. Often in the course of examination we find a very large prostate that is practically producing no symptoms. On the contrary, in another case we find one of apparently very small size that is producing the most active symptoms. The condition is best estimated by the result rather than by its size and shape. I am of the opinion, as the result of some little thought and study, that the cystoscope in the diagnosis is unnecessary. The symptoms together with a digital examination, possibly aided by a sound in the bladder, are all that is necessary. The whole

symptom complex, the changes in urine, urethra, bladder, ureters and kidney, are all explained by the residual urine. It causes cystitis, the cystitis causes frequent desire for urination, frequent urination increases existing congestion, and all of these in turn may bring on retention of urine. The catheter is used, infection is very liable to occur in a bladder already congested. The retention and affection of the urine produces circulatory changes in the kidney. The quantity of urine is increased and a vicious circle is established. If the predominant urinary obstructions be not removed, it will quickly affect the patient's health.

In the differential diagnosis. Atony, simple in character, is perhaps the most difficult. The symptoms may very closely simulate those of prostatic hypertrophy. The patient will find himself required to strain intensely to start the flow of urine, he will be a long time in emptying his bladder, in consequence the frequency of urination will be increased, and it may be impossible to differentiate: but passing the catheter and palpating the prostate should clear this up. Of course this atony may be due to stricture; then it is not so simple a matter to exclude prostatic hypertrophy, although the age of the patient will be of great value in making a diagnosis.

Cystitis when not due to prostatic enlargement, or stricture has no residual urine.

I have seen on rare occasions paralysis of the bladder mistaken for hypertrophy but more often the reverse is true. The attending physician makes a diagnosis of paralysis when he has an enlargement of the prostate, to deal with.

A calculus of the bladder will not be mistaken for an enlarged prostate, unless it is both firmly fixed and thickly coated with mucus so that no grating is imparted to the sound. About one in four of these cases are complicated by the presence of a calculus. Bleeding is more common when the calculus complicates the enlarged prostate. Pain is frequent and constant while in uncomplicated prostate enlargement it is usually an insignificant symptom. Frequency of micturation is during the day. These patients are not much disturbed at night. The X-Ray will at times detect the presence of a calculus.

Likely the most difficult thing to differentiate is a polypoid growth in the bladder, springing from the region of the prostate. It may simulate a pedunculated "middle lobe" of this organ, but we should remember that in nearly all forms of vesical tumors, other than prostatic, spontaneous hemorrhage is an early and conspicuous symptom and is usually not attended by much pain.



Fragments of the growth are frequently passed in the urine. A microscopical examination of these fragments will solve the difficulty.

Tuberculosis of the bladder may occasionally simulate an enlargement of the prostate, but this is frequently accompanied with similar disease elsewhere in the body; most often in epididymitis

Abscesses of the prostate usually follow an acute infection, The history of the case, sudden onset, rapid enlargement, pain, sepsis with obstructive symptoms, will arouse our suspicions, Palpation will reveal a mass usually one sided. If permitted to remain unopened, this abscess will rupture into the urethra, rectum, or perineum, making the diagnosis certain.

There is another condition that a great deal is written about, described as sclerosis of the neck of the bladder, and has been especially studied by Chellenwood. Its symptomatology and morbid anatomy do not appear to differ materially from those accompanying inflammatory hypertrophy of the prostate, but by means of a combined examination, the absence of any enlargement of the prostate is readily determined.

Malignant disease is not common, and when present is usually carcinomatous. Sarcoma is extremely rare. Dr. Powers of Denver reports that he found in the literature, only six cases besides the one which he reported in the August number of the "Review of Reviews". Its most important symptoms is the great local or referred pain, which later shoots down the inside of the thigh and may simulate stone, by being felt in the end of the penis. The prostate is densely hard, enlarged and firmly fixed. Sarcoma when found induces cachexia more rapidly than carcinoma and the rate of growth is more rapid.

What is the prognosis and what can be done for these cases? will be asked. It is a question of much importance. There are but few diseases in which it is so necessary for the physicians to know what may be accomplished by the various methods of treatment.

It is not sufficient nor it is humane to hope that these patients will die of some intercurrent affection, before the necessity occurs for active treatment. Each case is a special study in itself.

To me there are two main questions to be answered. First; Can a patient's life be saved, prolonged, or be at least not sacrificed? Second, will his sufferings be relieved wholly or in part? Under medical treatment and the use of the catheter there is no prospect of terminating the patient's life. With a thorough

understanding that even when every antiseptic precaution is taken, in catheterization, his life may be prolonged and in some cases be very comfortable. It is true that some patients only have to pass the catheter once or twice in twenty-four hours, and will likely live a life of comparative comfort and likely die of some inter-current pneumonia of some other acute disease, but when the catheter has to be passed four to eight times a day and is attended with pain and difficulty, procrastination should not be considered at this day and age. The expectancy of these people is at the most only four years, so that clearly the life of the average patient is shortened by such treatment.

The next thought is drainage. It is in my opinion to be thought of only in an occasionally very debilitated subject, or in one very old. Drainage by a catheter introduced through the urethra can seldom be endured. We cannot forget the successes of Thompson and McGuire in treating these patients by supra-pubic drainage. My experience with supra-pubic drainage, has been limited to three cases, and as a result of that experience, I am impressed that if that was all the patient would allow me to do, at this date, I would absolutely refuse to do anything.

This method should receive little consideration, unless it is merely a preliminary step towards a radical operation. The same applies to castration, vasectomy, and ligation of the internal iliacs.

The Bottinii operations which a few men think very highly of, likely stands midway between the palliative and radical methods of treatment. I think it should only be spoken of to be condemned. The radical operations to be sure, have a distinct mortality, even when every mitigating circumstances have been considered, a few die from the operation itself. Possibly they would have lived a little longer, if left alone. To be sure it is important to use good judgment in selecting your cases. Each of us after some of our best efforts, asks himself, "had my treatment been a little different, would not the patient have recovered, or have lived longer? at any rate he would not have died as the result of my treatment."

My thoughts is that all of those cases with few exceptions should be subjected to an early operation, long before the secondary results to the bladder, ureters and kidney, have had time to develop.

I feel sure that the surgery of the prostate has a brilliant future, as much if not more than that of the appendix. Just

as soon as the rank and file of the profession realize how much can be done and how important it is that it should be done early these poor sufferers will not have to drag out a miserable existence.

The question as to the best route to attack the prostate has been settled in my opinion. The supra-pubic method has many advocates, and for a time seemed to have the best of it. My experiences have all been with the perineal route, and I am decidedly in its favor. From an anatomical standpoint, it is certainly the most rational of the two. In the vast majority of cases the removal of the enlarged prostate, does not meet all the indications. These cases do not get to us until the consequence of mechanical obstruction and infection has produced such changes that free drainage is absolutely necessary. Not all enlarged prostate can be removed by enucleation. I had one case in which the diseased organ had to be removed by Morcellement. It seemed as though we cut most of it away with the scissors.

I follow as nearly as possible the method of Parker Symes. but his rubber tractor so often gets punctured, or is out of order from some cause, that I of late, depend more and more upon the Young tractor to bring the prostate within easy reach of my index finger. So far the median incision has given it all the room I required. Perhaps we have been fortunate in not having very large prostates or very fat subjects.

#### DISCUSSION.

Dr. Sheldon, of Rosedale.—There was so much that was good in the paper I shall only speak of a few things. First of all, the statement that the doctor places gonorrhea as most often the cause of enlargement of the prostate, is one. It seems to me that it is a singular fact that many patients who have gonorrhea several times pass on through to an old age without enlargement of the prostate, and many times people with enlargement of the prostate give absolutely no history, and it seems that the majority of them give the history of not having had gonorrhea. It is true gonorrhea may produce inflammatory enlargement of the prostate but I believe there are many other frequent causes. One thing is the feature of congestion. We know that in varicose veins the fibrous tissues will become affected, the epithelial tissue may multiply. When we consider that the prostate, the same as the rectum, is suggestive to possible hypertrophy, and that these veins are large and numerous and not supplied with valves and often times the patient is constipated, we cannot ignore this fact.

He mentioned the Bottinii operation to condemn it. I will agree as a rule the Bottinii operation should not be used, but in this same paper we hear a report of a case of contracted neck of the bladder, removal of the prostate is unnecessary in these cases. The trouble is in the neck of the bladder and I believe the Bottinii operation will cure these patients, and as a rule it is less serious than removal of the prostate, and in all probability it will be seen that the successful results of the Bottinii operation have been in this class of cases rather than in the enlargement of the prostate case. We have read there is no definite relation between the size of the prostate and the symptoms produced, and it would seem in some of these cases the neck of the bladder was at fault and not the prostate itself and I believe the time will come when the Bottinii operation will be limited to this exception to the rule.



What is said about infection, drainage, etc., everyone will agree. Everyone will have a different technique.

Dr. Liggett, of Oswego.—I want to commend the paper; I think it was very excellent indeed. My experience is not large enough to make any corrections, and yet my study of the subject would indicate that carcinoma was more frequent than the doctor would indicate. He said it was very infrequently cancerous. My reading would indicate it is quite commonly cancerous.

I want to commend him on his idea about drainage. If the patient will not permit you to do the proper operation, I think we ought to hesitate a good deal about opening his bladder at all. I only did that one time, and the doctor says he has done that operation three times. He says he has done it for the last time, I have too, one is enough for me.

The matter of castration I take up simply to say in these cases he mentions where the patient is not very sick, passes the catheter twice a day and gets along comfortably, I think he will find a little operation will help him so much he can get along without a catheter at all. It is a very simple operation under cocaine. You don't injure the man in his sexual capacity. He has probably got where he don't want to raise a family, it don't take away the desire and his feelings are the same and you do give him relief. I have cases where they got along very nicely; they are not cured but to a man who refuses prostatectomy and yet wants some relief it is the best thing we can give. I think this is a surgical ailment and not medical, all the drugs you can give him will not do him much good.

Dr. L. R. Sellers, of Osawatimie.—The paper was a very interesting paper. There are some things in it that I may believe after studying it more. The doctor's assertion that gonorrhea was a very important factor in the large prostate. I am not prepared to accept that just now. My practise has been largely in the country, and I have found in country practise where country people are all supposed to be chaste, that about one in four of all old men after they reach the age of 65, suffer from enlarged prostates. In the city I know a city doctor where most every case that comes to him is a probability of venereal disease, he is easily led into that line of thought and that conclusion, but the paper was interesting for the treatment. I have never been able to do anything for those cases. An old man would come to me, had been using the catheter, his whole idea was simply when and how to empty his bladder, and I always felt the sooner you die the better for you. I was never able to do anything for him and I would like to hear, when Dr. Munn closes his discussion, the results of his operation, and if he can promise anything for old people whom I can do nothing for I will send him some of those who come to me.

Dr. Bowers, of Wichita.—I have been very much interested in this paper from more than one standpoint, and more especially from the speech of the last man on the floor. He is old in years and he has seen the results with the old men that the younger members of the profession have not seen so frequently, and this is the most important thing that this paper brings out to this body is the necessity of arriving at a conclusion whether these cases are medical or whether they are surgical, and when the time comes that they are no more medical they should be turned over to the surgeon. There is no more pitiable object in the world than a man that has been described by the man who just left the floor. There is no other patient that gives you more satisfaction and is more thankful for what you have done for him when you have relieved him of the condition he has suffered from retention of urine. Then if we can arrive at a conclusion and know what is best for these people, that we should do, that the general practitioner should do. The surgeon meets with these cases last; they don't consult him first; they consult their family physician, the general practitioner, and the surgeon gets them as referred cases only. It does not benefit the general practitioner to hang on to a case he cannot do any good, and he does something else, he holds the case with the object of searching his text books to see whether he can do something for him, and they are so indefinite. Prostatic surgery is just making its evolution today. Ten years ago we knew nothing about it; five years ago we began to hear something about it, but there is very little in the text book that helps



the general practitioner today. We must look to our Journals, to the reports of men who are doing surgical work.

As to the etiology I have attempted in 47 cases I have had to determine something about it. I have been unable to come to any conclusion. Reading the writings of the men who have done the most work along that line, they seem to be unable to come to any conclusion as to what is the true etiology. It is supposed about 34 per cent of males who arrive at 60 years of age possess large prostates, and about 50 per cent of those suffer from retention and diseases that follow the retention. I am inclined to believe the infection we find is secondary and that primarily we have to do with a fibrose condition of the prostate. I have operated supra-pubically on 31 cases. 18 of those cases I have done what is known as partial prostectomies. My first work and my first attempt at prostate surgery was through the peritoneum. I had a some bad luck and I had a case that lead me to do a supra-pubic operation and since I have done my first supra-pubic operation I have never done a perineal operation since.

The anatomy of this organ when it is thoroughly understood I believe will give us a very good idea of the location of the prostate. The prostate in studying embryology, is a gland in the bladder wall and it is not until puberty, there is a "V" shape in its embryonic state, and it is not until puberty when this gland begins to develop and the internal sphincter develops after puberty. The outer sphincter is beyond the prostate gland. This prostate gland is held up in this capsule by the fascia that comes from the perineal fascia.

Dr. C. C. Nesslerode, Kansas City: There is one thing that has not been mentioned that is the usual cause of death, and when surgical interference is justified, and that is the ultimate outcome of these men, that is pyonephrosis, and the one thing that comes to me is this: We read so many times that people die of senility at 68 and 70. I have often wondered if it wasn't probable that a large per cent of these men died of prostatic hypertrophy and infection of the bladder. I remember one autopsy I did on a case, a man of 68 years old; he came in giving a history of some stomach trouble, and in taking his history and going over the abdomen found he wasn't having a perfect control of his bladder, and after examination found he had an infected bladder and infection of both kidneys, one was much enlarged and tender and the other was not. The man had never had gonorrhea, he came to the doctor telling a story of stomach trouble. He remained in the hospital for ten or twelve days until he died, and vomited continously and at the autopsy the one kidney that wasn't palpable had gone through the stage of pyonephrosis, was thin and contracted a little larger than your two thumbs, it was so small one might easily have said "Here is a man with one kidney, the other not being developed" but it was found it simply represented the stage of pyonephrosis. Had that man lived long enough I think the second kidney would have gotten to the same stage as the one involved. The end of all these fellows is going to be just like that one unless they are operated upon. We got a good many cases of old men in the hospital, and the work there in prostatic manipulations has been very encouraging, old men who have gotten to the age of 70 and had to use the catheter for some months because of retention of the urine. I remember one man that recently was brought 300 miles, hadn't passed urine for 30 hours, and the prostate was removed and in the course of three weeks he went home. He was out of bed the fifth day. It is a bad business to put them on their backs and keep them there. Another man was out of bed in the third day. They both went home perfectly well, and a man like that is surely to be congratulated. It seems to me there is no other class of cases that offer more encouragement to do work, and so many men are not doing prostatic manipulation. It is certainly a field of work that needs attention. The work I have seen has most all of it been done supra-pubically.

Dr. McDonald: The paper has very interesting to me for a number of reasons, and especially from the fact I have now two cases. I have a man about 70 years old with a very large prostate, very little pain but he is greatly annoyed by having to draw during his sleeping hours. Then I have a case quite different of an enlargement of the lobe with a great deal of distress in a traveling man

about 36 year of age, and the cases present quite opposite charaters, and I am wondering what would be the chief factor in a case like that towards an operation, whether it would be the proper thing whether I could comfort that old man of 70 years of age or whether he would still suffer incontinence, and what I could promise the younger man. The paper was very interesting especially in view of these cases I have in hand.

DP. WALTHALL, of Paola—I am like all the rest of them, this paper interests me very much; in fact, we country doctors see a good many cases of it, and I believe most of the people who discuss this subject, even surgeons, talk along the line of the surgical treatment, but we country doctors cannot apply to the surgeons in every case, and it is my opinion there is one thing we overlook, and that is that a great many of our cases where there is retention, it is due to an acute inflammation, possibly due to the retention of urine and in all probability to passage of the catheter that has been unclean, and I have had to relieve a few of my cases by supra pubic drainage, a treatment Dr. Munn, I think, condemned, applied until you can reduce the acute inflammation, I think it is very well to do because I have seen a few cases it wasn't possible to introduce a catheter and in those cases I have just done the supra-pubic drainage until means could be used to reduce the inflammation, and then possibly they would go on for years. I have one case in mind as getting along very nicely that several different times I have had to drain his bladder the best way I could and use hot applications and do everything I could to reduce the inflammation, and after that he would pass along very nicely, and it is this thought I want to leave with the people, especially the country doctors that cannot do an operation at once or send their patient to the surgeon, and that is, don't rush into surgery until you have tried the other means, most of them have retention on account of acute inflammation and when that is passed by the rest of it can be handled.

DR. A. V. LODGE, of Iola—I have a case which came to me just yesterday, the case of a man 60 years old, I didn't know what to do hardly; he has been in charge of another doctor who has irrigated the bladder about three or four times a week and he has used electrical treatment. The gland is not so much enlarged but what he can pass his urine whenever he wishes to a little but there is a good deal of retention. I recommended an operation to the man, or suggested it as a relief but he will not submit. Am I to say I cannot do anything for him, and just let him go? He has had his other treatments, or am I to put him through the routine treatment which has been given? I wonder what would be the best thing to do. I would like to hear Dr. Munn suggest something.

DR. JONES—I wasn't going to say a word about this but there are one or two points that have not been brought out, and one of them is—What are you going to do for your old man of 70 or more who has already a pretty well marked pyonephrosis? It has been my observation these cases in the hands of most operators, men of unquestioned ability in the line of operative procedure, that they lose a very large majority of their cases. I recall a series of three operations in one day by a man whose reputation is a by word in the American profession, and all three of these cases had well marked pyonephrosis, and all of them died inside of 36 hours, and I find that is not an unusual consequence in those well marked cases of pyonephrosis. Those men are really moribund when you get hold of them. There are men that are doing more of that kind of work than I am, but this is the kind of a case I pass by. If he has gone on until there is absolutely nothing else to do, if he has reached that age, your mortality rate is going to be so high that if your patient understands it he will not submit to operative procedure; therefore I should say in all of these prostatic cases don't let your operative procedure be your last resort, and watch your mortality rate. When we make this a process of selection we are going to get better results. In a small hospital how are you going to treat these old cases? In the very small number I have had they have about emptied the hospital of all other cases. The odor that comes from those cases from the perineal route is something frightful, and it is going to last for several days. You have got to get him up. You can irrigate his bladder

but there is going to be soiling and you will have an odor that is going to scent up all your hospital. I have tried various means of combatting it but not successfully.

The point Dr. Munn didn't bring out in etiology is traumatism. In a large number of cases I have found I could discover some trauma preceding the actual history of prostatic trouble. In some of those cases infection has come after the use of the catheter.

DR. CASSELL—In regard to the question what we shall do with men who refuse the operation, I have had to solve that in two cases. I have a man 82 years old who refuses an operation because he says it is useless, and an other old man 76 or '8 years old who has been on the complete disability pension list for 20 years, both of them greatly enlarged prostate and retention of urine. Those men I know have been under treatment for four or five years. They are just as well now as when they came under our care. We have done everything possible to do, we have irrigated with boracic acid and salt solution and done everything under the sun. We have had them under catheter, and the men are alive; if they had been operated on probably both of them would have died. They probably would have been better off if they did, but they would not do it and we had to keep them alive.

DR. MUNN, (Closing the discussion)—I thank you for this liberal discussion. Many of the questions have been answered. I declared my position in the paper. Beginning with Dr. Jones, why should you wait at this day and age until all these dire results have happened when you can promise this man relief before all these things occur; why wait, once your man has residual urine, once he is getting up at night, that man is a subject for operation. Because one man lives 20 years with a catheter and boracic acid, and 99 out of the hundred die in four years as the result of the catheter, why is there any argument in that at all. These cases are all surgical.

As to results my experience has been some 26 cases; all of them have gotten well. I expect the next set will all die. That is my answer to what you can do for them.

About my results, about smell, etc. you will have your drainage out in 3 or 4 days, you don't have any soiling, and the vast majority of these cases will every hour or two empty their own bladders. All of these 26 cases, and only one case still has perineal fistula; all the rest pass their urine the normal way.

In an operation about two weeks ago, about the time we got through, Dr. McGuire who was assisting asked "Is the rectum all right?" an examination showed that we had a complete connection into the rectum. We closed it with a double row of chromic gut, sweat blood for a week or ten days; but it closed and has made no trouble. The choice of routes I suppose, is largely governed by ones experience. I am prejudiced in favor of the perineal route. I worked through it more often, but occasionally I have gone supra-pubically. In the particular case, that I got into the rectum, the better route would have been above the pubis, for we found that after we had gotten into the bladder; that the cause of the obstruction was the third lobe; that the lateral lobes practically were not enlarged. This third lobe acted almost as a ball valve. There was one thing in his clinical history that made us wouder. He would pass three or four ounces of urine comparatively freely, and it would suddenly stop. This should have been a warning sufficiently marked that the supra-pubic route was preferable. It is possible that there is an occasional case that the Bottinii operation might be advisable, but the selection of the particular case, is too refined for an ordinary mortal.

I say to these people, there are two propositions up to you. You can go on using the catheter and take your chances but it is too dangerous to take chances with it. There will come a time when neither you or your family physician will succeed in passing the catheter, then the chances are that it is too late for a successful operation of any sort. The secondary changes in the bladder, ureter, and kidneys will be so great, that an operation offers nothing.



## THE FAUCIL TONSILS, THEIR ANATOMY, PHYSIOLOGY AND REMOVAL.

Read before the Kansas Medical Society of Iola, May 7th, 1908.

DR. J. F. GSELL, Wichita, Kansas.

The faucial tonsils are two glandular bodies lying just internal to the angle of the jaw and between the anterior and posterior pillars of the soft palate. They are flattened, ovoid in shape, and in early adult life about three-quarters inches in general dimensions.

Histologically the tonsils consist of adenoid tissue of the same character as the lymph glands. They reach their maturity early and in this respect they agree with lymph glands generally, which are more active physiologically in early adult life.

The tonsil itself consists of a stroma of connective tissue containing the blood and lymph vessels and within the lymph meshes of the connective tissue lymphoid follicles, these show a close analogy to Peyer's patches and solitary glands in the intestine.

They are superficially situated being covered only by mucus membrane, their surface is uneven containing from twelve to fifteen cryptal orifices formed by the invagination of the epithelial layers of the mucus membrane, thus largely increasing their secreting surface.

In the wall surrounding the crypts are found numerous nodules, without, however, directly communicating ducts, their contents being discharged directly through the epithelial walls.

A sulcus generally divides the tonsil from a lower smooth and an upper cryptose portion.

The crypts in the upper part of the tonsil opening upward into the supra-tonsillar fossa, a triangular space at the top and back of the tonsil covered by the plica-triangularis. These crypts because of their location are often the exciting cause of trouble in the tonsil and should not be overlooked when searching for source of inflammation or infection.

Considering the size of the tonsils they have a remarkably free blood supply, this being derived from the tonsillar, lingual, facial, internal-maxillary, and pharyngeal arteries.

Their nerve supply does not seem to be well understood, branches from the trifacial and glosso-pharyngeal supply them and possibly fibers from the sympathetic.

In considering the physiological function of the tonsils one meets with difficulty, as varying opinions are given by different investigators, some consider them indifferent organs, that could



easily be dispensed with, while others hold that they are important organs of protection and should be preserved at any cost.

Bort argues that if the tonsils have a similar histological structure to the lymph glands, hence we may assume that they have a similar function, that they serve as filters for the afferent lymph current, and that they produce lymphocytes just as the lymph glands do, and in addition, because of their superficial location being covered only by mucus membrane their cell secretion is discharged externally on the mucus membrane, these cells do not reach the surface through any special channels or duct, but by penetrating the vessel walls and mucus membrane, the intercellular tissue uniting at once thus preventing the formation of any openings.

Hendelsohn injected soot emulsion with a fine hypodermic syringe into the tonsular tissue and was able to observe microscopically (after the removal of the tonsil) that the wide leucocyte current carried the foreign bodies to the surface of the tonsil.

Federici observed that finely ground carmine granules suspended in normal salt solution, which he injected into the venous system of dogs became visible a day later in the tonsillar epithelial partly free and partly included in the leucocytes, by injecting bacterial suspensions in the peritoneal and pleural cavities he observed the same phenomenon.

Goeike injected carmine suspensions into the venous system of rabbits and later found pigment granules in the tonsils as well as in other organs.

The result of these experiments rather demonstrate that the lymph current in the tonsil, or at least part of it is from within outward, and that the tonsils secrete lymph cells and possibly lymph serum upon their surface.

Wood has shown that by injecting aniline dyes into the tonsil tissue, that the tonsils drain into the superficial glands of the neck and from there into the deep crevical glands beneath the sternocleidoid muscle.

Goodale of Boston demonstrated that by applying a carmine solution to the surface of a tonsil and after a short time its removal that particles of the carmine were found in the follicles, and that an occasional leucocyte with a particle of the carmine in it, and if the tonsil was left some time before the removal of particles carmine could be seen in the lymph vessels.

The experiments of Wood and Goodale go to show that at least a part of the lymph current is from without inward and that the tonsils drain into the glands of the neck and that by communicat-

ing with the axillary and mediastinal glands general infection and involvement of the lungs could readily take place.

As the result of these investigators which we have given, those of Hendelsohn, Federici and Goeike demonstrating that a lymph current takes place from within outward, and those of Wood and Goodale that a lymph current takes place from without inward, seems to me logical to conclude that both are correct, that in a normal tonsil the lymph current is largely from within outward, and that lymphocytes and lymph serum is secreted upon the surface of the tonsil. Whether this secretion helps to reabsorb the excess of saliva in the mouth or in the excess of the post nasal secretion, or whether it aids in the reabsorption and assimilation of the carbohydrates, the digestion of which begins in the mouth, or whether it aids in the lubrication of the throat during the act of deglutition, may be conjectured, but has not been proved.

It is reasonable to conclude however, that the chief function of the faucial tonsils, as well as that of its neighbors, the pharyngeal tonsil is one of protection. That they are placed at the entrance of the respiratory and digestive tract as barriers to ward off infection, and that while a tonsil is in a normal state or capable of doing its duty it should not be disturbed. While on the other hand, if it becomes diseased we can readily understand how this harmless organ of protection can be changed into a dangerous one of infection, as long as its epithelium remains intact there is not much danger. Repeated inflammation of the tonsil may produce stricture of the crypts or cryptal orifices, this in turn favoring retention of exfoliated epithelium and secretion, thus forming an excellent nidus for bacteria, tending to destroy its epithelial covering forming areas of necroses or small abscesses. A tonsil may present in a general way nearly normal appearance and yet because of these small areas of necrosis in the crypts may be a dangerous tonsil.

Considerable has been said and written about the tonsils being the source of infections such as articular rheumatism, tuberculosis, scarlet fever, in fact, we might include in this category nearly all of the infectious diseases. If we have a tonsil suffering from an erosion or necrotic areas as described above, we can readily see how such infections may take place. In examining a suspicious tonsil for source of trouble, we should always carefully examine the crypts with probes before we can eliminate the tonsil as the possible source of infection.

When Shall We Remove a Tonsil?—1st. If we find a large hypertrophied gland that interferes with respiration and deglutition.

2nd. If by repeated inflammations the tonsil is composed chiefly of connective tissue, at the expense of its glandular element and is a source of irritation, congestion and inflammation to its neighboring parts.

3rd. When it is the subject of necrotic areas that do not yield to treatment, in fact, in a general way, a tonsil that is a frequent source of trouble and does not yield to proper internal and local treatment had better be removed.

Tonsillotomy.—After we have concluded to remove the tonsil, how can we best accomplish this purpose? Tonsillotomy is often looked upon as a simple procedure, we will agree that it is easy enough to remove a third or one-half of almost any tonsil, but to remove all or a large part of the gland in many cases is not easy of accomplishment.

Tonsils have been removed for centuries and a great many varieties of instruments have been devised for this purpose, probably the most widely used instrument is the Mathews tonsillotome or some modification of it. My preference, in a large majority of cases regardless of the size of the tonsil, is a heavy cold wire snare, or curved pair of scissors, I believe it better to remove all or nearly all of the tonsil in every case we operate upon, except the large tonsils we occasionally see in children which show a physiological hyperplasia due to infection in the nose or throat or some increased glandular action, which by their size produce difficulty of respiration especially during sleep. In these cases a partial removal is all that may be necessary, but in practically every other condition if the tonsil is to be interfered with, it better all be removed.

If the operation is to be performed under local anaesthesia, the patient should be seated facing a good light. Make a few applications of the 10% sol. of cocaine to the surface of the tonsil and then inject into the base of the tonsil with a long needle a few drops of a  $\frac{1}{2}$  of 1% sol. of cocaine.

If there are any adhesions to the anterior or posterior pillars these should now be separated with the proper tonsil knife or scissors. If the adhesions are firm this may produce more bleeding than the removal of the tonsil. After the tonsil is loosed from the pillars it should be grasped with a pair of tonsil forceps, if the wire snare is to be used the forceps should be passed through the loop in the wire before grasping the tonsil, the wire should be passed well over the tonsil while gentle traction is made upon the forceps, for this reason I generally use the forceps in my left hand while the patient or an assistant uses the tongue depressor, then while pressing the canula well in to the base of the upper anterior

part of the tonsil begin to use traction on the wire snare. The wire will naturally pass through the part of least resistance which is back of the posterior membrane of the tonsil. A submerged tonsil or a small fibrous tonsil that could hardly be touched with a tonsillotome can be entirely removed in this way. While the removal with the snare possibly produces more pain, it leaves a smaller wound, there is less bleeding at the time of operation and less tendency to hemorrhage later.

If the operation is to be performed under general anaesthesia a mouth gag should be used, otherwise the operation is performed in the same manner. If the scissors are used the tonsil should be grasped, after being loosened from its pillars, with the tonsil forceps and separated by one or more bites of the scissors. In a normal tonsillotomy there is not much else to do except keep the patient quiet and on liquid diet for several days. After the first 24 hours it is well to spray the throat or have the patient gargle with some mild antiseptic sol. three or four times daily. I do not let the patient use a gargle the first day for fear of dislodging blood clots and producing secondary hemorrhage.

About the only accident that is likely to occur during or after a tonsillotomy is hemorrhage, and one should always be prepared for such an emergency. The books recommend the application of ice, iced gargle, gallic and tannic acid solution, the preparations of iron, adrenalin internally and locally, in fact, almost every astringent in the pharmacopea could be mentioned, as a matter of fact I doubt if any application applied, will control a hemorrhage of a serious nature. I have never had but one case of severe bleeding, this occurred in a young man nineteen years of age about five years ago. I removed large tonsils in my office with the Mathews tonsillotome, the operation was an ordinary one, no unusual amount of hemorrhage at the time of operation, I asked the young man to rest in the reception room for an hour or so before leaving for his room, just as he was about to leave he coughed and cleared his throat rather forcibly and at once began to bleed freely, I had him use ice water gargle to which I added Monsell's sol. of iron, this checked the bleeding for a few moments when the blood pressure would dislodge the blood clot and he bled again, during the afternoon I used different astringents, it seemed any of them would check the bleeding for a short period, then the blood clot would loosen and he would bleed again, I could not locate any special bleeding point or I would have attempted to grasp it with a forcep. After repeating the above seance with different astringents a number of times during the afternoon, I took the boy to the hospital, he did



not bleed on the way, but the moment he laid on the bed, he called me, the blood just gushing out of his mouth, I grabbed a piece of cotton, placed it over my finger, dipped it in iced tannic acid sol. and placed it over the base of the tonsil using considerable pressure. This at once stopped the bleeding, I held my finger as long as I could, then the interne took my place and used the same pressure ten or fifteen minutes longer, this procedure checked the bleeding which did not return. At different times if a tonsil is bleeding more than we like to see, I reach in over the bleeding tonsil with my finger and use pressure for a few moments and in every case the bleeding has ceased. Instead of wasting much time in a bad case of bleeding with the application of astringents, etc., better at once use pressure over the bleeding tonsil by means of some of the tonsil clamps or the finger. If the bleeding point can be located and grasped with a pair of forceps and either tied or torsion used, or the forceps can be left in place for some time.

**To Conclude**—1st. The tonsil is a glandular organ and secretes lymphocyte and leucocytes upon the surface and while in a normal condition is an important organ of protection.

2nd. That it may become diseased and changed from an organ of protection to one of infection, and should be removed.

3rd. That when its removal is attempted as much of the tonsil should be removed as possible except in the physiologic hyperplastic tonsils in children, when a partial removal will suffice.

DR. WEAVER, of K. C.—So far as the indications given for removal are concerned, I think the doctor covered the field very well, except, if he mentioned it, I didn't hear him say anything about the ear troubles that sometimes accompany enlarged tonsils where there has been no active inflammation or abscess of the tonsils themselves. So far as the history of tonsillar operations go, I had some occasion to look up the subject recently, and it might be of interest to some of you to know that tonsils were removed either by finger handling or by blistering as far back as ten years after the birth of Christ. The operation remained practically the same for a long time until about 1500, when Pira and one other man had probably some bad results and for a time they decried any operation whatever. From the year 1600 to 1700 the operative procedure has been in vogue and has been the method of treatment ever since. The tonsils were dissected in the year 1777 by a Frenchman, and that has been the method of treatment ever since. There is one point I want to mention, that is, this being frequently an operation in which hemorrhage is feared, the location of the principal blood vessels of the neck must be borne in mind. I don't think that the internal carotid or external carotid has ever been injured in tonsil operation or perforation by the knife. The reason is the internal carotid artery lies from 1-8 inch from the exterior margin of the tonsil and about  $\frac{1}{4}$  inch external to it, and the external artery lies still more out of the way. The arteries which are more likely to be injured are the branches which the doctor mentioned.

As far as the methods of removal are concerned there are practically five that are done today. One, the latest method of tonsillotomy, which has been modified by Matthew with a fork, that is, the sliding kind, where the knife slides in a groove, and the other type which is ring knife. The second is the snare method, and the third is what is called multiple puncture

and the fourth is cutting forceps and the fifth is dissecting methods. As far as the first is concerned, I believe it is growing less and less in use every day. I had the privilege through the kindness of Dr. Head to see the advance sheets of the Eye, Ear, Nose and Throat books for 1908, and it says the trend is to discard the tonsillotome altogether, because it does not do what it is supposed to do.

The doctor prefers the snare method, which I don't like because it is so much slower. The forceps method, there have been half a dozen different forceps put on the market in the last dozen years. They bite off a little bit at a time and you keep cutting off the same blood vessel and you get a new hemorrhage each time. The methods, I think, which are mostly in vogue are the dissecting methods, done with knife or scissors, and one with electric cautery dissection. It has the advantage of almost doing away with any hemorrhage altogether, but it has the disadvantage of leaving the throat sore afterwards.



## ANTITOXINE IN DIPHTHERIA WITH REPORT OF A CASE.

Read before the Kansas Medical Society at Iola, May 7, 1908.

DR. FARQUHARD CAMPBELL, Kansas City, Kansas.

Probably no drug in any period of time, ancient or modern has revolutionized the treatment and so greatly decreased the mortality of a disease as has diphtheritic antitoxine. This fact alone warrants a study of it by the profession, and the many pleasant experiences I have had with it in my practice suggested this paper.

Before the days of antitoxine, diphtheria was probably the most fatal of all diseases. It was a night-mare to physicians and struck the hearts of parents with horror, often wiping out an entire family in from twelve to twenty-four hours.

With the advent of the crude serum in the large old-fashioned bulk, the death rate began to diminish rapidly and as the serum went through its various stages of reform to become of a uniform strength, a decrease in mortality was rapidly taking place. This refinement progressed until today we have practically a perfect product with a very low death rate, and the chemists are only trying to decrease the bulk of the packages and to remove certain soluble proteids which have a tendency to produce rashes, etc.

A few lines on the chemistry of diphtheria would not be out of place. Diphtheria toxine, according to "Ehrlich" is composed of three principal parts, I. E. toxin, toxoid, toxone.

The toxin in the most active, can only be neutralized by its own antitoxine, being the one that causes the acute phenomena of diphtheria, such as high fever, prostration, cloudy swelling and fat-

ty degeneration of the heart, muscles, kidney and cells. This is the one responsible when sudden death occurs in the acute stage.

It is a peculiarity of toxins that they lose a certain amount of their toxicity in the course of time. In the words of the bacteriologist, the toxophorous group may degenerate and leave the haptophorous group intact. Toxins which have undergone this change are called toxoids. But in giving antitoxine it must be remembered that this non-toxic toxin or toxoid still retains its affinity for antitoxine.

The toxone is much slower in its formation and action, attacking the nerve cells and may produce death by paralysis a month or six weeks later. Besides these three main divisions there are many others as the syntoxids, prototoxids, etc., but as all of these can be neutralized by antitoxine the paramount question with the physician is "what is the required dose to counteract these toxins?" Here he must be guided by the constitutional symptoms and the number of days the patient has been sick. The longer the time and the greater the toxemia, the larger should be the dose.

In selecting a suitable location to give the serum I always choose the abdomen or chest where the skin is loose. The needle is liable to leave a tender area and this factor is not increased by lying on it as in the back. Also if the spot becomes irritable, treatment can be applied, without disturbing the patient and in children it is easier because they can see what you are doing.

Much has been said regarding the dose of antitoxine and I do not feel capable of giving it to you gentlemen. This is only the recognized treatment for diphtheria but every case must be a law unto itself. I might as well say that the dose of calomel is one quarter grain, but all give it till the desired result is obtained, regardless of dose, so the same intelligence should be used in giving antitoxine and that is "get the physiological effect you desire, whether the dose be one-thousand units, one-hundred thousand or three-hundred thousand units.

The initial dose must be governed by your toxemia and the greater the toxemia the larger the dose. Children as a rule, are more susceptible and a much larger dose should be given. The appearance of the throat is not a sure guide to your condition as the throat may be entirely covered with apparently little constitutional disturbance and these causes readily yield to a small dose while again the throat may be clear or nearly so from membrane and the patient be prostrated with toxemia.

It seems strange that a drug that has reduced the death rate to a minimum should be regarded, by the laity with such suspicion.

This seems to be caused by their attributing every sudden death to the antitoxine, and probably strengthened somewhat by indiscriminate remarks by the profession. In the administration of large doses, the physician has often to combat some fears in his own mind, or in that of a fellow practitioner, but he always has to fight the superstition, prejudice and ignorance of the people themselves. But the laity are now facing the problem where physicians refuse to treat diphtheria when they cannot get permission to use the serum.

While cases may develop paralysis with the most scientific use of serum I see no reason why it should be attributed to that source. Many more cases had paralysis with sudden death following before the use of serum, but since its advent many very bad cases which would have otherwise died, have recovered. If we accept the views of "Ehrlich" that a special toxin with a weak affinity for antitoxine, is the "toxoid," causes paralysis, we find all the more justification for a large dose of antitoxine, for antitoxine neutralizes the toxoid as well as the toxin. Let us endeavor to educate the people with a little reason and a few plain facts. So strongly do I believe in the serum that it is my opinion every case of diphtheria could be saved if seen during the first twenty-four hours and sufficient antitoxine used. While I have never known a case when I thought too much antitoxine had been given I have seen several when I knew the initial dose had been too small.

There are certain proportion of cases which have such slight initial symptoms as to be entirely overlooked by the parents. The throat becomes covered with membrane and the physician is called because the patient is having difficult breathing and is becoming cyanotic. If any case demands a large initial dose this is the one, and more especially so if intubation is necessary. In these cases where quick results are so necessary the serum can be injected into a vein without danger and the complete action is several hours earlier.

The effects of antitoxine are practically nil, for the first few hours, when the temperature may be slightly raised and the pulse becomes faster but usually stronger. The patient begins to perspire which function may become profuse and be associated with copious expectoration. When the perspiration starts the temperature falls, the pulse decreases in frequency while the moist throat and mouth adds much to the comfort of the patient and greatly facilitates breathing.

Many cases develop nervous symptoms about two hours after the administration of the serum, or before perspiration becomes es-



tablished, which is manifest by restlessness, tossing about, etc., Very often the size of the dose has no relation to the mental disturbance, but age seems to have some bearing as children are the most susceptible and in them it is the most easily controlled. In my experience, I find Dovers powder best and if given about the same time as the serum, will control it. In adults or those who have received a large dose, morphia 1-8 to  $\frac{1}{4}$  gr. will be sufficient.

When the toxemia becomes less and the membrane begins to exfoliate I know the antitoxine has completed its work. In a few cases the membrane may become black and shriveled and may cling to the original spot but if the constitutional symptoms show an absence of toxemia, I remove the membrane with gargles.

The after effects of antitoxine are many but rarely serious. For some time the manufacturers have been trying to separate the antitoxine from the proteid non-antitoxine substance the serum contained. To a large extent this has been accomplished and our present concentrated serum or globulin is free from all but the soluble proteids. We are largely indebted to Dr. R. C. Gibson, of the Research Laboratory for this work, and as a result, the rashes, etc., are greatly reduced.

The most common sequelae are:— (1) Rashes—may be local or general, sometimes resembling scarlet fever and in one case fine exfoliation followed.

(2) Urticaria—may be near the needle puncture or involve the whole body.

(3) Rheumatic Pains in joints—which are usually confined to one or two joints.

(4) Anaemia.

For first three, free elimination of the bowels, kidneys and skin with strychnia or strychnia arsenate; and for the fourth some suitable iron tonic with manganese quinine, and arsenic.

This practically sums up the antitoxine part of my paper and I will now report my case.

This interesting patient was my associate, Dr. A. J. Lind, but first I will report a case where he believes he contracted the disease.

CASE I—Girl, thirteen years of age, sick twelve days, membrane in throat and mouth which parents supposed was stomach rash. Dr. Lind was called because of toxæmia and prostration of patient and found the throat, mouth and cheeks full of membrane which also protruded from the nostril. Patient very toxic. Thirty-five thousand units were administered in thirty-hours membrane entirely disappeared. For forty-eight hours patient's tem-

perature normal pulse 60 to 72, constitutional symptoms fine, patient able to talk, and laugh. She suddenly jumped to a sitting position in bed and fell back dead.

CASE II.— Called to see Dr. Lind on Dec. 29th, at noon, throat red, glary and very sore but no membrane, as the diagnosis was already made I brought 5000 units of antitoxine which I gave. At 6 P. M. membrane began to appear and another 5000 units was administered.

Dec. 30, 7:00 A. M. —Membrane increasing with oedema 5000 units more given,

Dec. 30, 7:00 P. M.—More membrane and oedema 10,000 unit dose.

Dec. 31st, 3:30 A. M. Throat very dry and painful. I gave 5000 unit package I had with me, very toxic and delirious.

Dec. 31st, 10:00 A. M. throat, tonsils and soft palate entirely covered with membrane, throat so oedematous that tonsils were in apposition, toxemia more apparent. 25,000 units administered.

Dec. 31 10:00 P. M. —Patient had a better day, pulse better and mouth moist but no decrease in oedema membrane. 25,000 units given.

Jan. 1st, 1908. 10:00 A. M. patient had a better night, profuse perspiration and considerable expectoration after midnight. Oedema seemed to be less and membrane seemed to be slightly loose in spots at the edge. 20,000 units administered this caused some perspiration but in the afternoon the mouth, throat and nose became very moist with profuse expectoration, and cast of the membrane coming away. Oedema was diminishing. By night all constitutional symptoms much improved and patient resting comfortably. The following morning Jan. 2nd, the membrane was entirely gone the oedema rapidly diminishing and little evidence of toxemia to be noted. From here on his recovery was rapid and uneventful. The nervous symptoms were only present after the large doses. The first was entirely controlled by one eighth of morphia hypodermically, the second, with one-quarter grain, the third with one eighth grain. About one week afterward he developed an attack of urticaria which rapidly yielded to an eliminative treatment. The case was seen by Drs. Sawtell, Mabie, Stemen and Trimble.

## IRITIS.

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Read before the South East Kansas Medical Society, April 14, 1908.

By A. C. GRAVES, M. D., Pittsburg, Kansas.

In taking up the subject of iritis, I think it well to have a classification of the disease so far as the cause is concerned. Further than this, authors differ.

In classifying iritis in regard to etiology, we may first name traumatic; secondary, as from a corneal ulcer; and those forms occurring from constitutional disease, such as rheumatism and syphilis.

Because of the great tendency of the inflamed iris to adhere to the crystalline lens, the diagnosis should be most prompt as the prognosis hinges greatly on this point. One very seldom sees a patient until after the first twenty-four hours; after it is later. The patient presents himself complaining of great pain, loss of vision, photophobia and lachrymation. The pain as a rule, and especially in the severer forms, radiates backward through the head, and sometimes over the entire side of head and face. This should be enough to put the physician on his guard and a careful examination should follow.

We note upon inspection, a general congestion of the eyeball and if slight pressure is made upon the superficial vessels at the sclero-corneal margin, and, as it were, blotting out the superficial congestion, we will find that beneath this there yet remains a congestion of the deep ciliary vessels. On close examination, a certain amount of turbidity of the aqueous humor can be detected. This accounts for the loss of vision which is in direct proportion to the cloudiness of the media. In iritis we find a small sluggish pupil and this in connection with an iris which has lost its beautiful lustre together with the previous symptoms and history, should warn the physician to be most careful in making his diagnosis.

I think it well at this point when examining a case, to put the eye and patient as near at rest as possible. Yet, at this point, because of the slight similarity in acute glaucoma and iritis, it is well to take the tension of the inflamed eye before instilling any medicine. In acute glaucoma we find the hazy and anesthetic cornea the semi-dilated pupil and the plus tension.

In putting the eye at rest, I use cocaine, and because of the mydriatic effect of this drug, we have gained a valuable point in forming our diagnosis, for, in an inflammatory condition of the iris it will probably not respond at all to the mydriatic effect of the

drug. When these signs and symptoms are present, atropine should be commenced, and a sufficient dilation will soon be present, so by means of the ophthalmoscope, minute spots of iris pigment can be seen on the anterior surface of the lens, being left there from the synechia which were broken up by the mydriatic.

Thus far, we have been dealing with an eye having a media which is more or less clear. Now, when dealing with an iritis, secondary from points of infection as from corneal ulcer, one cannot use the ophthalmoscope; but a physician may feel sure that with an ulcer involving the deeper layers of the cornea there will surely follow an inflammatory condition of the iris. Here, as before, we will have an involving of the deep ciliary vessels, with possibly a hypopyon.

At this point, I think it well to stop and observe the changes which will occur in a neglected case of iritis. The first thing which will occur is the formation of a posterior synechia which soon becomes a posterior annular synechia. When this has occurred it becomes impossible for the aqueous humor secreted from the ciliary body behind the iris to escape from the posterior chamber into the anterior chamber. The results that follow are that the tension of the eye becomes plus, the iris becomes bulged forward and the filtration angle becomes blocked so that all avenues for the escape of the aqueous becomes interfered with, leaving the eye in a condition of secondary glaucoma. Also in the acute stage of the disease with an annular synechia present, inflammatory exudates are often thrown out and completely occludes the remaining pupillary space. It is evident from the great destruction to an eye resulting from neglected case that an early diagnosis should be made so that proper treatment may be at once commenced. In those cases resulting from trauma, atropine, if used so that a complete dilatation is maintained until the inflammation has disappeared is usually all that is necessary, so far as the care of the iris is concerned and preventing synechia from complicating any other trouble which may result from trauma. I will cite a case which I think will illustrate the importance of caring for the iris early when we have trauma of any extent to deal with: Patient, Mr. Z. Italian; occupation, miner; age 32. One week previous to visit at my office, an explosion of powder occurred, patient receiving force of explosion in eyes. There was no penetrating wound in either eye. Examination. Right eye upper and outer portion of iris adhered to lens substance in anterior chamber. Lense cataractous. Left eye, lense opaque, swollen and protruding into anterior chamber. The iris adhered in several places



to lense substance. I saw patient one week after accident and previous to this, no mydriatic had been used, and as a result, synechia had formed, which complicated the condition greatly.

In those cases occurring secondary, as from corneal ulcer, the ulcer being the seat of the trouble, should receive careful treatment according to the individual case. The pupil here should be kept well dilated to prevent adhesions. In handling a case of iritis in a patient past 45 years of age, the physician should be very careful in regard to the use of atropine. If adhesions have formed, I believe only sufficient atropine should be used to dilate that portion of the iris which is not adhered, and then just enough to maintain the dilatation and keep the eye at rest. For this reason, I give the following case.

Mrs. E., occupation, housewife; age 50 years. For two weeks previous to her visit to my office, patient was taken with severe pain in right eye, which also became greatly inflamed. Patient had a mist before the eye preceding pain. She thought at first, that her glasses needed changing. This history, as you see, was very suggestive of another trouble. Examination. Tension good; further examination revealed a posterior synechia of iris involving the inner and lower portion of pupillary margin of iris.

I commenced the use of atropine, the free portion of iris responding quickly to the drug. I then used atropine sufficient to maintain this dilatation. The following day patient was free from pain and in eight days from first visit the inflammatory condition had almost subsided.

As the constitutional diseases are responsible for the largest per cent of iritis, I wish to devote the rest of this paper to their treatment; and as syphilis is responsible for a greater per cent, I will take this form of iritis.

Iritis occurring from syphilis is usually seen during the secondary stage, and we are usually able to find the secondary eruption upon the body. With this history and by a careful examination of the eye, as has already been mentioned, a diagnosis can be made at once.

As the patient is usually suffering the most intense pain, I deem it necessary to put the patient and eye as nearly at rest as possible. I first try to accomplish this by relieving the eye. The patient should be put to bed if possible and atropine commenced at once and maintained in such a manner that a complete dilatation is produced. When this has been obtained, its use can be restricted to a sufficient quantity to maintain the dilatation.

In commencing the treatment of iritis, the physician should

watch the effects of the atropine upon the iris carefully during the first instillations, because if adhesions have formed it is absolutely necessary to know the extent. It is entirely wrong to prescribe atropine and allow the patient to use it himself and dismiss him for the day. Allow me to repeat, that the extensiveness of the synechia must be determined, for if it becomes necessary to force the use of the mydriatic, it is better this at once. In this case the constitutional symptoms must be watched carefully. Before commencing the rigid constitutional treatment in the acute stage, every avenue of elimination in the body should be opened, and I find no better remedy for this purpose than calomel. I commence it a once; giving 1-10 gr. doses every hour during the day, sometimes skipping every other day. It is also thought by many that calomel adds greatly in breaking up the adhesions between the iris and the lense.

One of the most difficult symptoms a physician will have to combat is pain. During the day, I prefer to control this as near as possible by means of heat; but during the night the patient's rest must not be broken, so resort must be had to morphine, if necessary. As is often the case, the tension of the eye becomes plus and this adds greatly to the pain, so it is well to give the patient a lotion he may use himself. A useful one is:

Cocaine, gr. ss

Aquae Camphor. one drm.

Aquae Dist. Q. S. two oz.

M. Sig. for pain.

Here also dionin may be used because the drug aids in reducing tension and also stimulates the lymphatic circulation. If the tension of the eye increases, some authors recommend paracentesis, but I would do this only as a last resort to relieve my patient.

The constitutional treatment is equally important to the last. Suffice to say that the full effects of mercury must be produced and maintained according to the physician in charge. Later I would continue the mercury with potassium iodide. After the eye has recovered, it should be carefully examined and if a few synechia remain, there will likely be no bad results from them. In those cases of iritis where complete posterior synechia is the result, an immediate iridectomy should be made for the purpose of restoring the circulation between the two chambers and warding off such a sequela as secondary glaucoma and blindness.

## SOME POINTS IN THE TREATMENT OF FRACTURES.

Read before the Kansas Medical Society, at Iola, May 7th, 1908.

By JOHN G. SHELDON, M. D., Rosedale, Kansas.

In the treatment of fractures, the position of important muscles and the deformities which they may produce, are most important considerations. This is especially true in transverse fractures of the lower end of the humerus. In these injuries, the triceps displaces the lower fragment posteriorly and must receive attention. It is generally agreed that in treating these cases, dressing the forearm in acute flexion offers the greatest opportunity for securing union without deformity. Acute flexion of the forearm, advocated by Lund, Smith, Cotton, Whitman, and others, should be accomplished by fixing the wrist and forearm to the shoulder rather than to rely on strapping the forearm to the arm with adhesive plaster which is sometimes recommended, but is inefficient because the looseness of the skin allows the forearm to extend and the constriction of the plaster interferes with the circulation.

Fractures of the Forearm.—It is advised, as a general rule, in treating fractures of the forearm, to dress the part midway between pronation and supination, for in this position the radius and ulna are most widely separated. To this rule there is one marked exception which is too often unrecognized, and which if overlooked, will result in marked limitation of pronation and supination after the fracture has united. I refer to fractures of the radius (with or without fracture of the ulna) situated above the insertion of the pronator radii teres and below the supinator brevis. When the radius is broken in this location, no muscular attachments remain on the upper fragment to overcome the action of the supinator brevis which turns the upper fragment outward. The lower fragment should be brought in line with the upper; and of course, this means that in the treatment of this particular kind of fracture the member should be dressed with the hand in complete supination.

Colle's Fracture.—Reduction is the all important consideration in the treatment of Colle's fracture, and to accomplish reduction, the fragments must be unlocked and placed in proper position without injuring the dorsal fibrous and perisoteal bridge which long ago was so graphically described by Pilcher of Brooklyn, and which, prevents a recurrence of the deformity after reduction, as efficiently as it interferes with setting the fracture. To reduce a Colle's fracture, the hand and lower frag-

ment should be hyperextended on the forearm. This unlocks the fragments without tearing the dorsal bridge of ligament and periosteum which is not torn in this variety of fracture. After the fragments are unlocked, their dorsal edges are approximated with the operators thumbs. Then flexion of the patient's hand completes the reduction. This is a very old, but most efficient, method for reducing Colle's fracture. Although used by some men of wide experience, this best of all methods of reducing Colle's fracture, has not found its way into the text books of surgery published since 1885.

**Fracture of the neck of the femur.**—It is generally admitted today by those who have studied fractures of the neck of the femur, that extension in the longitudinal direction alone is inadequate to secure the best results. This is true because the muscles attached to the great and lesser trochanters pull the femur towards the pelvis and their force is not overcome by longitudinal extension. The psoas, iliacus, glutei, and obturator muscles draw the femur towards the median line and must be overcome by lateral extension. This is accomplished by the method advised by Maxwell and elaborated by Ruth. Besides the application of an ordinary Buck's extension to the thigh, a weight is so applied as to pull the upper part of the femur outward and upwards. The result of these two forces makes extension in the direction of the normal neck of the femur and completely overcomes the deformity. Whitman accomplishes the same result but I believe in most cases not so efficiently by dressing the femur in complete abduction. Regardless of the method employed, provision must be made to overcome the action of the muscles which draw the femur to the pelvis, for the result will not be satisfactory unless the lateral deformity is given consideration.

**Pott's Fracture**—This old and very well understood fracture is some times improperly treated. In a practical way Pott's fracture may be divided into two classes: (1) those in which the lower end of the fibula is completely loosened from the tibia and (2) those in which the lower tibio-fibular articulation remains intact. When the fibula is not detached from the tibia (which can be determined by the mobility of the parts) the foot should be dressed in marked inversion, regardless of the extent or location of the bony injuries. But if the lower end of the fibula moves freely on the tibia (the so called Dupuytren's fracture) then the foot should be only slightly inverted and a firm dressing should be placed around the lower tibio-fibular articulation, to prevent separation of the bones of the leg above the ankle joint.



# THE JOURNAL

## OF THE

# Kansas Medical Society.

JAMES W. MAY,

EDITOR.

J. E. SAWTELL,

{ ASSOCIATE EDITORS }

CHAS. S. HUFFMAN.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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## EDITORIAL

If every County Secretary will do a little "boosting," our State Society membership would in a short time reach the 2000 mark where it belongs. Some counties have every eligible physician enrolled and a great many others have not. Lets all get together and make our society which is now solid as a rock, even more so.



A knowledge of medical science and the application of it has enabled our government to build the Panama Canal. These same principles enforced will enable Uncle Samuel to make habitable and enormously profitable, the one hundred million acres of swamp land in the United States which is now used principally for breeding mosquitoes.



The Secretaries of the State Medical Societies and editors of the State Journals held a meeting at the Victoria Hotel in Chicago June 2nd and formed a permanent organization. The idea of the association is to help in all ways possible the struggling

state journals and to eliminate all advertisements of a questionable nature and in all ways stand together. There were forty-two delegates at the meeting, your secretary and editor representing the Kansas Medical Society. The organization is destined to be a great factor in medical journalism and will result in much good being accomplished. The next meeting is to be held at Atlantic City, N. J. June 1908.



To the average intelligent layman or practitioner of medicine, it would seem that the witches, oriental, hindoo, voodoo, indian and what not doctors did not have near so gullible a field to draw upon, as the christian scientists, faith healers, and other frauds do at this day. It seems that with all the modern inventions and progress in every line that has been the result of much study and scientific investigation, there has resulted in a loss of the ability to grasp and understand the simple problems of life. It seems that this form of mental aberation is not confined to what is called the middle classes but has taken hold of some of whom we used to speak of as thinking people. How much we were mistaken by calling them thinking people can be learned. by consulting the role of the so called scientists, faith healers, spiritualists etc. Will the time ever come when every new fraud that is foisted, will cease to gather adherents, fall by the wayside and die an early and lonesome death.



According to Crile (Journal A. M. A. June.)

"Cancer is curable in its incipency"

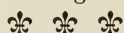
"There is a pre-cancer stage".

"There is no specific therapeutic cure".

"The knife is the most reliable means of treatment".

The duty of the physician then is clearly one of publicity and of education. It is the duty of the family physician when consulted about a wart or objectionable excresence of any kind on the body, to advise removal of the adventitious growth. Impress upon the mind of the patient the danger of delay and that such growths are unnatural, in the sense of abnormal, and while all such growths may not become malignant or lead to death, such is the beginning of all such growths. That the removal of them is safe, that they can be removed with but little discomfort and it is the only assurance of cure. That a wart or mole on the face, by the friction or rubbing, in washing the face and drying with the towel, may result in a cancer. Such advice given on every occasion would be a campaign cancer education.

The law passed by Congress prohibiting the use of opium in the Phillipines except for medicinal and scientific purposes went into effect March 1, 1908. Hundreds of users of the drug are now being treated at the Public Health and Marine Hospital in the islands. The physicians report the majority of patients easily cured. It is worthy of note that those who used the drug hypodermically suffered the most on withdrawal of the drug. Smokers were easily cured, and those who ate it were more difficult to cure. Will some physician tell us why the use of the drug hypodermically should be harder to break off than smoking or eating it? Is it true of other drugs used in the same way.



Many investigators are arriving at the conclusion that the ophthamo-tuberculin is not a safe procedure. Loss of vision following its use has been reported by Hamil, Carpenter and Cope in papers read before the Association of American Physicians May 12th and 13th at Washington (New York Med. Jour. June 20, 1908). Others, Rosenau, Anderson, Northrup and others before the same society also reported the danger. It was the belief of many that the cutaneous reaction was reliable. Certain it is that the cutaneous reaction is harmless and time will show that it is just as reliable as the ophthalmic reaction. That there is considerable value to the tuberculin reaction as a means of early diagnosis there can be no doubt but it is equally certain that it is not infallible, for it has been proven that many advanced cases will not reach at all to this treatment. It is estimated that 75 to 80 per cent of the tests are true.



The appalling results of trachoma would suggest that a campaign for its prevention would also seem imperative. This disease which is no respecter of persons though more common among the middle and lower classes has reached a stage that in some countries the government has taken a hand in attempting its eradication. The United States emigrant authorities will not permit emigrants with trachoma to enter this country. Some states notably New York and Illinois have for some time attempted to educate the laity as to its prevention. The question also resolves itself into arousing the physicians to increased activity by: instructing his trachoma patients and other members of the family as to its contagiousness and how to prevent its spread, by such simple measures as patients individual basin and towel and bed etc. It is true that many, many times this disease spreads through all the members of a family leaving them more or less

incapable of earning a livelihood and it is also true that a large percentage of cases could be prevented. Why not, then, have increased activity and less trachoma?



Chicago has just witnessed what in many respects was the greatest medical meeting in the history of the world. In point of attendance it surpassed anything of its kind ever held in this or any other country. In completeness of every detail it cannot be surpassed. It was heard on every side that the sectional work could hardly be improved upon and the entertainments provided by the Chicago Physicians was a success in every particular. The opening meeting at which the incoming president Dr. Henry L. Burrell gave his address was held at the Auditorium Tuesday morning and the reception to the president at the Coliseum the following Wednesday night. The exhibits were displayed at the armory on Michigan avenue. The society had as visitors from abroad E. Treachor Collins, London, Chas. Edward Beevor, London; Edward Albert Shafer, Edinburg; Albert Jansen, Berlin, August Martin, Greifswald; Ernest Ferdinand Sauerbruch, Marburg; Johannes Pfannenstiel, Kiel.

The officers elected were:—

President, Dr. William C. Gorgjs, Ancon, Panama.

First Vice President, Dr. Thomas Jefferson Murray, Butte, Mont.

Second Vice President, Dr. John A. Hatchett, El Reno, Okla.

Third Vice President, Dr. Thomas A. Woodruff, Chicago, Ill.

Fourth Vice President, Dr. E. N. Hall, Woodburn, Ky.

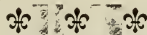
General Secretary, Dr. George H. Simmons, Chicago, Ill., re-elected.

Treasurer, Dr. Frank Billings, Chicago, Ill., re-elected.

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## NEWS NOTES

Dr. M. T. Sudler of the University of Kansas will spend his summer in Cleveland and elsewhere studying the methods of teaching operative surgery.



Dr. W. K. Trimble of the University of Kansas is spending his vacation visiting the laboratories of the eastern universities, particularly Harvard and Pennsylvania.



Dr. H. L. Chambers of LeCompton who was recently elected Students' Physician in the University of Kansas will move to Lawrence and take charge of the new students' hospital there this fall.



Dr. Geo. H. Hobson University Medical, 1908, has located at Valley Falls, Kansas.



Dr. C. B. Stemen of Kansas City, Kansas, spent the months of May and June travelling in the east and attending the conference of the Methodist Church as a delegate,



THE UNIVERSITY OF MISSOURI has found it impossible to begin its work at St. Louis in September; therefore the last two years of its work will be given for another year, at any rate, at Columbia.



Dr. B. F. Morgan of Clay Center, Kan. was out of commission a couple of weeks last month. Cause—A stone bruise on his shin (a hematoma) caused by a base ball in motion being estopped on the afore said member.



Dr. S. P. Millard of Carbondale, Kans. has removed to Topeka and has formed a partnership with Dr. Theo. W. Peers. Dr. Peers is one of the older Topeka physicians and a teacher and leader in the treatment of childrens diseases.



The School of Medicine of the University of Kansas will re-open Wednesday, September 16, the entrance examinations being held on the 16th, 17th, 18th and 19th. The first lecture for the clinical apartment will be given on Monday, the 21st.



Dr. A. B. Oechsli bought the office equipment of Dr. T. C. Hinkle of Stockton, Kansas, and succeeds him in his business. Dr. Oechsli is a recent graduate of the University Medical of K. C. Mo. and former manager of the W. M. C. foot ball team.



Dr. F. M. Tracy of Kansas City is a candidate for the Republican nomination of Representative for the 11th district. The doctor is a member of the Kansas Medical Society and a co-partner of Dr. S. S. Glasscock in the Grandview Sanitarium.



Dr. C. W. Haverkamp has been elected Superintendent of the Eleanor Taylor Bell Memorial Hospital of the University of Kansas. Dr. Haverkamp has had considerable experience in charge of hospitals in connection with the United States navy and is therefore well fitted for the position.

Dr. J. P. Stewart of Clay Center was a delegate to the Democratic National Convention at Denver in July, which nominated Bryan for president.



The Post-Graduate Medical College in Kansas City, Mo., which was organized some time ago is making rapid strides toward success. In many departments the clinics are all that can be desired. The trustees have purchased the building formerly occupied by the Medico-Chirurgical College on Independence Avenue and it is used for a hospital and an out door clinic. Kansas City is certainly well able to support a post-graduate medical school and the starting of this one is timely.



Program of Decatur and Norton Co. Medical Society June 30, at Dr. C. G. Brethouwers office, Norton, Kansas.

Cholera Infantum . . . . . S. C. Standard

The A. M. A. Meeting of 1908 at Chicago, W. C. Cole  
Clinic

Round Table Discussion

C. G. Brethouwer, Pres.

C. S. Kenney, Sec'y.

June 25, 1908



The ordination exercises and the graduation exercises of the School of Medicine of the University of Kansas were held at the Coates House, Kansas City, Missouri, on Monday evening June 8. The attendance of the out of town guests was almost entirely prohibited by the high water. However, the program was successfully carried out. Dr. Palmer Findley, Professor of Gynecology in the University of Nebraska, delivered the ordination address on "The heroes of medicine." At the banquet Dr. Jacob Block acted as toastmaster and the speakers were Doctors Hoxie, Wood, Sawtell, Cissell, Glasscock, Woodin and Mr. Irland. The formal graduation exercises were held at Lawrence, June 10. Governor Johnson of Minnesota was the speaker of the occasion. The doctorate address was delivered by Reverend Clay Cissell at the Methodist Church at 7th and Washington Streets, Kansas City, Kansas, on Sunday morning, June 7.



EDITOR OF THE KANSAS MEDICAL JOURNAL,  
Kansas City, Kans.

Dear Sir:—I am giving below a copy of a resolution which was passed by the Labette County Medical Society at its meeting

Wednesday, June 24th, which I was asked to forward to your Journal for publication.

Whereas reliable statistics show that tuberculosis is responsible for one thousand two hundred deaths in Kansas annually; therefore be it

RESOLVED, That this Society heartily favors the project of the State Board of Health to establish an institution for the treatment of tuberculosis, and that we request the members of the Legislature from this district to do all in their power to promote this project

Yours truly,

H. P. MAHAN, Sec'y. Pro. Tem.



Kansas furnished her full quota of physicians at the Chicago meeting of the American Medical Association. Those registered are as follows:—

Alkire, H. L., Topeka; Blue, Robert B., Wichita; Bressler, A. H., Nickerson; Carlile, J. B., Leon; Langworthy, S. B., Leavenworth; Mahan, H. P., Parsons; Moore, R. M., Olathe; Patton, C. L., Olpe; von Trebra, R. L., Chetopa; Brewer, J. F., Minneapolis; Button, Edwin C., Great Bend; Clark, J. D., Wichita; Cornell, Howard M., Kansas City; Cummings, J. S., Bronson; Daniels, E. N., Beloit; Davis, O. P., Topeka; Gardner, M. G., Greenleaf; Glasscock, Samuel S., Kansas City; Graves, W. H., Wichita; Guy, S. J., Winfield; Hagan, Martin, Wichita; Hawley, J. E., Burr Oak; Huffman, Chas. S., Columbus; Jarrett, M. F., Fort Scott; Johnson, A. C., New Murdock; Koentz, C. H., Onaga; Love, J. E., Whiting; May, James W., Kansas City; McCullough, W. A., Delavan; Menninger, Charles Fredric, Topeka; Miller, M. A., Newton; Phares, W. A., Wichita; Porter, M. C., Clay Center; Priest, W. K., Concordia; Reynolds, L., Horton; Seacut, Geo. M., Cherryvale; Sawtell, J. E., Kansas City; Smethers, W. H., Moline; Sterrett, Wm. P., Kansas City; Stewart, J. P., Clay Center; Stough, D. F., Stockton; Tooley, Geo. E., Washington; Trueheart, Marion, Sterling; Trusler, L. S., Fall River; Wilson, F. M., Nortonville; Adams, Wm. A., Easton; Ball, Samuel E., Mapleton; Barnes, Ida C., Topeka; Bowers, C. E., Wichita; Braucht, F. E., Wichita; Caffey, Hugh B., Pittsburg; Cole, Charles W., Norton; Davis, J. W., Independence; Davis, Josephyne E., Ottawa; Dinker, Otto F., Sylvan Grove; Dorsey, J. G., Wichita; Edgerton, Wm. M., Dwight; Esterly, D. E., Topeka; Flack, A. C., Fredonia; Fuller, J. A., Lane; Grove, W. T., Eureka; Gsell, J. F., Wichita; Harkey, W. C., Gardner; Harper, Frances A., Pittsburg; Hamilton, Geo. L., Kansas City; Henderson, A. G., Leonardville; Jones, Llewelyn L., Altoona; Lindsay, W. S., Topeka; Lutz, Earnest J., Kansas City; Meade, Reginald H., Great Bend; Minn, D. P., Aldin; Minney, J. E., Topeka; Murdock, S., Jr., Sabetha; McCarty, Claude E., Dodge City; McKay, Wm. T., Arkansas City; McVey, W. E., Topeka; O'Brien, D. S., Beloit; Pigmain, S. C., Concordia; Poole, John G., Kansas City; Purdue, G. C., Wichita; Reynolds, C. W., Holton; Sams, L. V., Topeka; Sawhill, W. F., Concordia; Shelton, F. W., Independence; Shonkwiler, T. M., Burns; Stelle, H. L., Pittsburg; Steelsmith, Simon, Abilene; Walker, O. D., Salina; Warriner, W. L., Topeka.



The following 81 physicians passed the Kansas State Board examination held at Kansas City in June:—

W. M. Anderson, 1968 North Third street, Kansas City, Kas.; S. G. Ashby, Pleasanton, Kas.; S. D. Anderson, Kansas City, Mo.; W. C. Brashear, Odessa, Mo.; C. L. Beeching, general hospital, Kansas City, Mo.; E. E.

Brooks, Burden, Kas.; S. T. Bayles, St. Joseph, Mo.; E. L. Beard, Waukomis, Ok.; Albert Beam, Wilsey, Kas.; W. C. Burnaman, Hollenburg, Kas.; W. H. Blankership, Howard, Kas.; J. B. Close, Norton, Kas.; L. F. Chapman, 1610 Central street Kansas City; D. B. Craig, Kansas City, Kas.; J. F. Cave, Simpson block, Kansas City, Kas.; J. F. Coffman, St. Joseph, Mo.; J. C. Dings, Mound City, Kas.; C. C. English, University of Kansas hospital, Rosedale, Kas.; E. T. Erickson, 225 West Fifteenth street, Kansas City, Mo.; A. M. Fortney, 706 West Tenth street, Kansas City, Mo.; A. C. Field, Paola, Kas.; A. M. Gorton, Rialto building, Kansas City, Mo.; S. C. Hatlen, Indiana building, Kansas City, Mo.; G. E. Haughey, Leavenworth, Kas.; L. E. Haughey, Topeka, Kas.; Z. G. Houser, Madison, Kas.; J. K. Hawey Salina, Kas.; G. L. Harrington, Independence; G. H. Hiltz, 301 Independence avenue, Kansas City, Mo.; G. K. Hobson, Kansas City, Kas.; C. W. Hendrickson, Corbin, Kas.; B. A. Isenberg, Collyer, Kas.; N. L. Johnson, Green Castle, Mo.; W. H. Kirkpatrick, Abbeyville, Kas.; G. M. Kendall, Englewood, Kas.; O. G. Keller, Bernard, Kas.; H. P. Knowles, Topeka, Kas.; L. A. L. A. Kellar, Bernard, Kas.; L. E. Lee, Weatherby, Mo.; S. Lawson, Weston, Mo.; C. B. Magee, Cunningham, Kas.; B. I. Mills, Atwood, Kas.; W. W. Miller, Osborne, Kas.; L. B. Miller, Kansas City, Mo.; G. W. Matthewson, Brancroft, Kas.; J. L. Miller, jr., Norton, Kas.; J. R. Newton, 3615 Smart avenue, Kansas City; Paul Newlon, Lincoln, Kas.; C. M. Newman, Albany, Mo.; A. B. Oechsle, Stockton, Kas.; E. F. O'Malley, Hope, Kas.; C. C. Price, Versailles, Mo.; B. B. Parrish, Kirksville, Mo.; Stanley Poulina, 3536 Central street, Kansas City; W. H. Perry, Chillicothe Mo.; C. J. Ryan, Purcell Kas., H. D. Riordan, Delphos, Kas.; F. H. Riney, Dodge City, Kas.; M. W. Rogers, 1205 the Paseo, Kansas City, Mo.; B. F. Roe, Chanute, Kas.; P. A. Riddles, 3114 Chestnut street, Kansas City, Mo.; S. H. Snow, 702 Spruce street, Kansas City, Mo.; H. C. Schmidt, Iola, Kas., W. B. Stewart, Lenexa, Kas.; K. D. Saunders, Jonesboro, Ill.; L. J. Swann, Lansing, Kas.; P. W. Sweet, Marquette, Kas.; E. E. Sweeney, Ravenwood, Mo.; Herbert Tuthill, 902 Independence avenue, Kansas City, Mo.; J. G. Woodin, 902 Independence avenue, Kansas City, Mo.; R. B. Wittich, Mount Sterling, O.; R. S. Whitaker, Coffeyville, Kas.; W. S. Winter, jr., Port wuthur, Tex.; G. K. Winslow, Oakley, Kas.; C. M. Wallace, St. Joseph, Mo.; E. L. Waterman, St. Francis, Kas.; B. J. McKay, Girard, Kas.; S. A. McCool, St. Joseph, Mo.; J. L. McDermott, Kansas City, Kas.; B. B. Mason, Grenola, Kas.; J. C. McLaughlin, Kansas City, Mo.; and J. L. Reed.



The regular meeting of the Mitchell county Medical society convened at the Woodmen hall Thursday, June 18, at 2. p. m. Physicians present, Drs. Brewer, Home, Daily, Daniels, Spain, Saunders, Antrobus, Seager, Edgerton and Cook.

#### PROGRAM

Report of clinical cases—Dr. Edgerton.

Reflex neuroses—Dr. Saunders

The papers were exceptionally well written and received a full and free discussion by all physicians present, making it one of the most interesting and instructive meetings held in the history of the society.

The following are some of the reasons why ethical physicians object to having their names connected in public print with the ills of their patients:

Sec. 2. Code of Ethics of the American Medical association: Secrecy and delicacy should be strictly observed, and the familiar and confidential intercourse to which physicians are admitted



in their professional visits should be guarded with the most scrupulous fidelity and honor.

Sec. 3. The obligation of secrecy extends beyond the period of professional services. None of the privacies of individual or domestic life, no infirmity of disposition or flaw of character observed during medical attendance, should ever be divulged by physicians except when imperatively required by the laws of the state. The force of the obligation of secrecy is so great that physicians have been protected in its observance by courts of justice.

Sec. 7. It is incompatible with honorable standing in the profession to resort to public advertisement, to publish cases or operations in the daily prints or to suffer such publications to be made.

WHEREAS, the press of Mitchell county contains daily or weekly notices making members of our profession conspicuous violators of the code, and fully realizing that the editors are not doing this with evil or malicious intent and would be among the last of our citizens would do aught to degrade the members of the Mitchell county profession in the eyes of the great medical profession of America, who respect and govern their professional conduct by the code, therefore

BE IT RESOLVED, that the president of this society appoint a committee of three in the city of Beloit and one member in each of the other towns in Mitchell county, where there is a daily or weekly publication, to confer with the publishers and request their co-operation in the future to prevent the names of the Mitchell County Medical society appearing in public print in any way connected with ills or sickness of their patients.

The preamble and resolution were unanimously adopted and the following committees appointed to confer with the editors: Drs. Daily, Home and Cook for Beloit; Dr. Blades for Scottsville; Dr. Saunders for Cawker City; Dr. Spessard for Glen Elder.

E. E. Brewer, President.

W. H. Cook, Secretary.



NOTICE TO COUNTY SECRETARIES:—I wish to call attention to those who are delinquent with their state dues and ask them to pay up at once. On Sept. 1st. all who are in arrears will be dropped from membership, and the Journal discontinued. I know that many are ready and willing to pay if their attention is called to it. Kindly notify all members in your county.

CHAS. S. HUFFMAN Secy.

**KANSAS MEDICAL COLLEGE, TOPEKA.: NOTES.**

The Nineteenth Annual Session will begin Wednesday, September 8th, 1908 for a term of thirty weeks.



The Washburn Catalogue for 1907 and 1908 shows a corps of one hundred teachers. Forty-one teachers of medicine in the Kansas Medical College and fifty-nine teachers in the other departments'



Topeka has five hospitals aside from the State Hospital. The latter has about one thousand patients.



Washburn College enrolled seven hundred and eleven students last year.



Dr. O. L. Roller of Centropolis, Kan. has been appointed assistant Medical examiner for the Knights and Ladies of Security Insurance Society with head-quarters in Topeka. He will give up his practice and locate in Topeka. This is one of the strongest mutual insurance organizations in the world. There are over eighty thousand members. The doctor will be assistant to the chair of Pathology in the Kansas Medical College.

**DEATH OF DR. W. H. SMETHERS.**

Dr. W. H. Smethers, of Moline, Kansas died very suddenly at his home on the morning of June 12th, 1908. He complained of not feeling well on retiring the night before but got up and answered a call during the night. When he returned he complained of a severe headache and took some nerve sedative to quiet the pain. While waiting for this medicine to take effect he asked his wife to hand him a bottle of chloroform, and after taking an inhabitation he immediately expired.

Dr. Smethers took an active interest in all efforts for the advancement of the science of medicine. He always attended the meetings of the State Society and by his presence and work demonstrated his interest in the state meetings.

The writer saw him a few days before he died at Chicago attending the meeting of the A. M. A. At the time he seemed be in the best of health. His death is a distinct loss to the profession of the State. The Journal wishes to extend to his family our sympathy in their great bereavement and assure them of the high esteem and respect in which he was held by the medical profession of the State of Kansas. CHAS. S. HUFFMAN.

THE EDWARD N. GIBBS, MEMORIAL PRIZE  
ONE THOUSAND DOLLARS.

SUBJECT:—THE ETIOLOGY, PATHOLOGY and TREATMENT of the DISEASES of the KIDNEY

THE NEW YORK ACADEMY OF MEDICINE announces that the sum of ONE THOUSAND DOLLARS will be awarded to the author of the best essay in competition for the above mentioned prize.

The subject of the essay, as stated, shall be, "THE ETIOLOGY, PATHOLOGY and TREATMENT of the DISEASES of the KIDNEY."

Essays must be presented on or before OCTOBER FIRST, 1909.

The three subjects mentioned in the title as above given, need not be treated with uniform fullness, but new discovery or fruitful research will be considered the standard of merit.

Each essay must be in English, typewritten, designated by a motto, or device, and accompanied by a sealed envelope, bearing the same motto, or device, which shall contain the name and address of the author.

No envelope will be opened except that which accompanied the successful essay.

The Academy reserves the right, according to the direction of the donors, not to award the prize if no essay shall be deemed worthy of it.

The Academy will return the unsuccessful essays, if claimed by their respective authors or by authorized agents, within six months.

An essay must show ORIGINALITY in order to obtain the prize.

The competition is open to the members of the regular medical profession of the United States.

The original of the successful essay shall be the property of the Academy, and, according to the deed of gift, will be published in its Transactions.

The essays shall be transmitted to THE COMMITTEE OF THE NEW YORK ACADEMY OF MEDICINE on THE EDWARD N. GIBBS MEMORIAL PRIZE.

JOHN A. WYETH, MD.,

President.

JOHN H. HUDDLESTON, M. D.,

Recording Secretary.

## CLINICAL NOTES

While every male child is not in need of circumcision, a large percentage of cases of "Colic"? in male children can be relieved by this slight operation.



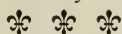
In prescribing eye-drops, order a dropper to be placed in the bottle in place of a cork as a stopper. It will always be at hand and always clean, and the solution will not be contaminated.—N. Y. Med Jour.



The diet of a patient in many cases is much more important than any or all of the drugs in the materia medica. An absolute milk diet for 30 days in asthmatic cases has been found to work wonders in many of the cases.



It only takes one gall stone to make a colic. The severity of the symptoms is not necessarily dependent upon the number of stones. In operating upon these cases one or two small stones in a distended bladder are easily missed.



A sterile scrub brush with sterile hot water and soap will take off more germs from a hand in five minutes, than a 1-1000 bichloride in several hours. If you are limited to one (which is not probable) choose the former.



DON'T take it for granted that a patient is suffering from bleeding piles just because he passes blood every time he has a movement of the bowels, because he may be suffering from prolapse of the sigmoid, ulceration, fissure, or cancer.—Amer. Jour. Surgery-



If a patient persists in running evening temperatures which cannot be accounted for after a thorough physical examination and blood examination, one should place the patient on increasing doses of the iodids, for the fever may be due to an old syphilitic infection.—N. Y. Med, Jour.



A quick way to handle an incarcerated fish-hook: Force the point with barb outward through the skin and rapidly incise the bridge of tissue between it and outgoing wound. This gives the open wound desired, which can be cauterized with carbolic acid and alcohol and dressed antiseptically.



In acute appendicitis the best prophylactic against opiates is an ice bag.



While the point of tenderness of pain is almost always located at McBurney's point in appendicitis, in a few cases it is not. In two recent cases, the pain in one was located above the crest of the ilium on the right side, in the other the only complaint of pain was in the lumbo-sacral region of the spine.



**TREATMENT OF MUSHROOM POISONING.**—Mahen, in *La clinique* summarizes the treatment of mushroom poisoning. The first thing to do is to evacuate the stomach by an emetic and then administer a purgative. In cases where there is contraction of the jaw, apomorphine should be given hypodermatically in a dose of one twelfth of a grain for adults. After the stomach has been emptied of the poisonous matter, administer demulcent drinks, such as milk, albumen water, etc. Apply a sedative application of camphorated liniment and chloroform to the abdomen, to overcome the fainting condition sinapisms may be applied, or hot coffee given internally, or hypodermatic injections of ether, or caffeine.—N. Y. Med. Journal,



**Iodine in the Treatment of Ulcers.**—In a communication to the *Journal of the American Medical Association*, for May 30, 1908, J. W. Roop, of Apache, Okla., says he has found the application of a saturated solution of iodine in alcohol to give excellent results in the treatment of ulcers. He began by painting the skin up to the edge of the ulcer, and this produced such good results that he ventured to use it on the surface of the ulcer itself. He has found that iodine used in this way in an efficient means of converting a septic ulcer into a clean, granulating wound which heals readily. He applies the iodine, either in "a concentrated form or a saturated solution in alcohol," every day or as often as is required until the slough separates, when an ordinary dusting powder and gauze may be applied. The iodine should then be discontinued, but if any unhealthy or superfluous granulations appear, it should be again applied. He says it quickly changes a phagedenic ulceration into a healthy condition, and speaks of other indications in which it has been serviceable, as in mouth and throat troubles, by painting it over the surface. It will arrest and cure pyorrhoea alveolaris. The application is usually painless.—N. Y. Med. Journal.

# THE JOURNAL

## OF THE

# Kansas Medical Society.

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### PSEUDO-LEUKAEMIA.

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By DR. H. W. MANNING, Eureka, Kansas.

Read Before the Kansas Medical Society at Iola, May 6, 1908.

I shall endeavor to present for consideration the history of a case of Hodgkin's disease as I have seen it; and a review of what literature I have been able to acquire. The history is about as follows:

H. L. S., 64 yrs, was examined at my office on July 18th, 1907, after having gone the rounds of various advertising medicine men. His family history is negative. The patient stated that he had always been in good health up to two years ago. He first noticed a swelling on the left side of his neck about the angle of the jaw. This steadily grew in size until at six months, it was half the size of a man's fist. There was no pain at first, but after three months shooting pains were experienced. After six months he noticed nodules above the collar bone on the left side, and a considerable nodule below his right ear. His left tonsil became so much enlarged as to render deglutition difficult.

An examination at the time he came to me showed a general appearance of decline. His neck on both sides were swollen even from chin to sternum and perfectly round as though no neck of regular symmetry existed. The left tonsil was broken down and sloughing out. Paralysis of the left side of the palate existed to such a degree that food and drink regurgitated through the nostrils. The axillary glands were markedly enlarged. The inguinal glands only slightly enlarged. The spleen was enlarged to quite a degree, and the liver seemed slightly enlarged. Examination of all other viscera was negative. Blood examination in September 1907 showed red cells 5,400,000, leucocytes 51,000, haemoglobin 80 per cent. I made a diagnosis of Hodgkin's Disease in this case,

basing it upon symptoms, duration of time of existence, and the character of the blood findings.

Pseudo-leukaemia is a chronic anaemia leading to cachexia, in which aside from relatively insignificant changes in the blood, nothing abnormal is found excepting a swelling in the lymphatic glands of the spleen, or both. The changes in the blood affect only the red corpuscles and their haemoglobin, and produce a number of symptoms dependent upon these lesions, particularly manifestations of hemorrhagic diathesis.

Pseudo-leukaemia admits of the same differentiation as leukaemia, depending upon the blood forming organs involved; we have therefore a splenic, a myelogenous, and a lymphatic form. Mixed forms between splenic and lymphatic varieties are especially frequent.

The disease has been given a number of names, which in itself shows how very obscure were, and still are, our ideas in regard to its nature. Thus it has been called adenie of Tousseau, Hodgkin's disease, anaemia splenica seu lymphatica, malignant lymphosarcoma by Langhans, malignant lymphoma of Billroth, etc.

On postmortem examination a wide spread cellular hyperplasia of the lymph glands and lymphatic follicles is found usually combined with an enlargement of the spleen, numerous lymphoid nodules in the interstitial tissue of the liver, spleen, kidneys and other organs; all changes corresponding to those of leukaemia.

ETIOLOGY,—The causes of this disease are unknown. We must consider different kinds of irritation exercising their effect for a long time in the region of the diseased glands, trauma affecting the spleen, attacks of intermittant fever, and possibly the existence of syphilis. Scrofulosis must be strictly excluded. Colonies of bacterium coli have been repeatedly found in pseudo-leukaemic spleen, but this find has little significance. Men are more frequently affected than women; the disease is found not infrequently in children.

The best pathological view of Hodgkin's Disease is perhaps that described by Dorothy Reed. Although the paper contains a very careful review of the literature on the subject, its chief value lies in the fact that it represents the most careful and painstaking study of eight cases of Hodgkin's disease observed at the Johns Hopkins Hospital that has yet been written. The main points of the pathological significance are described, as enlargement of lymphatic glands, absence of infiltration of the capsule, greyish surface broken by intersecting yellow lines; metastasis in the viscera

presenting a similar appearance though of irregular outline and apparently invading the organ in different directions. On section they present the same appearance as described in the glands. On microscopical examination there is found dilatation of the blood vessels and lymph sinuses, marked increase of lymphocytes and proliferating endothelial cells, numerous giant cells with one or more nuclei and prominent nucleoli in a great number. Occasionally a large giant cell with many small nucleoli peripherally arranged is seen. An increased number of eosinophiles is generally observed. Reed states that the capsule of the gland usually shows no change except possibly some thickening. This is not however, borne out by other authors, especially by Gibbons in his recent work.

The large giant cells are the most striking feature of the sections of Hodgkin's disease tumors. Reed states that they occur in large numbers in the larger lymph sinuses of the glands and are occasionally seen in the blood vessels. They vary remarkably in size from two or three to twenty times the size of a red corpuscle. Sometimes as many as eight or ten nuclei are seen in one cell.

The clinical picture of Hodgkin's disease is always characteristic. It nearly always begins with swelling in the cervical glands and may occur at any period of life, but most common in early years and in the male rather than in the female. The glands begin to enlarge on one side first; very quickly enlargement comes on the other side and a little later in the axillary region and last in the inguinal region, and in the internal viscera.

Although for the past twenty years numerous authors have attempted to maintain the tubercular origin of Hodgkin's disease, the most elaborate paper holding this view being that of Sternbergs, this theory has been so thoroughly controverted by many recent writers, particularly by Reed, that it can claim no further consideration. As in favor of the infection theory she sights the following facts: first, fever is frequently associated with the disease, to which Coley says that this is characteristic of sarcoma. Second, that the frequency with which it starts in the cervical region suggests infection through the mucous membrane of the mouth and throat, again Coley says that this would apply equally well to sarcoma of the neck. Reed states that the growths differ from sarcoma by absence of capsular infiltration and implication of adjacent tissue, and states that sarcoma does not confine itself by gradual extension from gland to gland.

Still another objection to the malignant theory, and one most frequently advanced is that metastasis occurs only in pre-existing



lymphoid tissue. Banti and Gibbons have both shown that metastasis occurs in Hodgkin's disease where there is absolutely no lymphoid tissue present. Five cases in which they had made autopsies showed metastasis over the entire body with metastasis in the liver, spleen, kidneys, lungs, pericardium and pancreas. In two they found metastasis in the structures of the neck, the fascia, muscles, and the cervical vertebra. The walls of the jugular veins were invaded.

In regard to blood examinations in the diagnosis of Hodgkin's disease, opinions vary. Reed and most writers believe that it offers nothing characteristic, although oftentimes there is an increase in the eosinophiles. Cabot in a series of thirty-two cases found a distinct lymphocytosis in eleven, DaCosta found three in ten, Langcope found one in eight, while Pincus of Berlin regards it as present in the majority of all cases. Coley also states that he found it present in several of his cases.

The number of red corpuscles is diminished, the haemoglobin diminished considerably more than would correspond to the decrease in the number of erythrocytes. A rapid reduction of haemoglobin is occasionally seen. The number of eosinophiles is not increased, nor are the cells containing red corpuscles present in great numbers in the blood; in the spleen however they are found in large quantities. The blood plaques according to many writers are almost constantly increased. In contra distinction Charcots crystals are never found in the blood of Hodgkin's disease.

Within recent years different authors have described cases of pseudo-leukaemia with attacks of recurrent fever and have called these conditions infectious pseudo-leukaemia or chronic recurrent fever. During the course of the fever the spleen increases in size, and decreases again during the period of apyrexia. Occasionally the glands situated near the surface of the body may become enlarged, chiefly the bronchial, retroperitoneal and mesenteric.

Canstatt, Sharlau, and Fuhrer, among the older authors, have described an enlargement of the spleen in chlorosis. They describe the spleen as very much enlarged, pale red, very juicy on transverse section, containing a parenchyma fragile and glandular. Chvostek found enlargement of the spleen in twenty-one of fifty-six cases of chlorosis which he observed in the medical wards of Vienna. In one series of cases a uniform reduction in the size of the tumor could be observed running parallel with the cessation of other symptoms of the disease and the amelioration of the condition of blood. If every other etiological factor that could produce an enlargement of the spleen could be ruled out, then

possibly we are justified in recognizing and assuming such a connection; in this case such a tumor would not be an accidental finding but be in relation to the general disease. Such cases of chlorosis with palpable tumors of the spleen, either hard or soft, form a transition to the case of splenic pseudo-leukaemia.

The prognosis is not influenced by the presence of a splenic tumor. In making a diagnosis of Hodgkin's disease we must always consider that in adults, and still more frequently in children, chronic tumors of the spleen and lymphatics may be found even in the absence of any recognizable etiological factor. As accordingly in children considerable pallor is observed, and at the same time no positive decision can be arrived at from blood examinations, it is frequently difficult to differentiate pseudo-leukaemia from a simple anaemia with glandular swelling. It is well to remember that pseudo-leukaemia is a disease of progressive character. This is manifested very clearly in the manner in which the lymph glands become involved. If these organs have become swollen they rarely recede; on the contrary they continue to enlarge which at the same time neighboring glands, or glands that are situated at a distance begin to participate in the disease process. They never show a tendency to amalgamate, to suppurate or to undergo caseous degeneration. They seem to remain isolated and can be palpated in all their dimensions. The skin over the glands remains intact and does not become adherent, and abscess formation does not occur. If all these factors are observed the lymphatic form of pseudo-leukaemia can usually be diagnosed.

It is hardly possible to confound lymphatic pseudo-leukaemia with other diseases. In the tuberculous form enlarged lymphatic glands are usually multiple and show a tendency to suppuration and caseous degeneration. The same may be said of scrofulous glands found in the region of the neck. In very difficult and important cases, glands have been extirpated for the purpose of diagnosis, and microscopic examination has usually revealed the true condition. If suppuration, cheesy degeneration, and calcification are found in the centre of the gland they should be taken as evidence of tuberculosis and scrofula. Cellular hyperplasia on the other hand, with or without thickening of the reticulum, speaks in favor of pseudo-leukaemia.

Nothnagle sights the following case to prove the difficulty in differential diagnosis between Hodgkin's disease and lymphosarcoma. "A boy of fifteen, otherwise healthy, developed a tumor in the left upper region of the neck, that was found upon extirpation to be a lymphoma. The patient recovered very well from the

operation. Half a year later pain increasing in intensity was complained of in the left abdominal region; the general health at the same time remaining unimpaired. The spleen gradually enlarged and ultimately formed a tumor of considerable size below the left costal arch: it was very freely movable and could be clearly diagnosed as a spleen from its position, outline and consistence. Laparotomy was performed and a tumor weighing two K.G. was removed. On extirpation it was found that this tumor had its origin in the spleen and contained a neoplasm that was a sarcoma or lymphosarcoma. Numerous glandular metastases was found in the hilum. Changes in the blood were not present before the operation nor were they found afterwards."

The prognosis of the disease is always bad. It is but little influenced by treatment. The length of time for the patient varies from six months to two and one half years.

The treatment is largely that followed in lymphatic leukaemia. Arsenic is the most recommended of all drugs. The drug may be administered internally or subcutaneously, or injected directly into the parenchyma of the gland. The action of the drug in external use is dynamic, and if much of it is employed, inflammatory and irritating. The fact that pathological cells can resist the irritating action of arsenic less than normal cells is of fundamental importance for therapy. We can conclude from this observation that even the internal administration of arsenic, owing to its dynamic action, will not interfere with normal cells but will seriously affect the abnormal ones and gradually lead to their destruction. Therefore the internal administration of arsenic should have some value.

Sometimes when arsenic has been used in the treatment of Hodgkin's disease the cachexia may increase, even though at the same time the general symptoms may ameliorate and the appetite improve. It is a very important fact that even the internal administration of Fowler's solution may produce inflammatory changes in the glandular swellings. Where the remedy is acting successfully the tumor increases in hardness and solidity in proportion to its diminution in size. Inflammation, suppuration and abscess formation may sometimes occur.

Parenchymatous injections of arsenic into the tissue of the spleen have been attempted. The results were occasionally good and the size of the organ seemed to decrease. Injections of quinine and carbolic acid have been tried with some success. Its a good plan to precede the injections by a course of treatment that renders the quantity of blood less in the glandular system by action upon

the contractile tissue. The best method of producing this result is by using ice bags over the region for several hours.

Swelling of the glands seemed to decrease by the internal use of phosphorus and antimony. The former remedy is best administered in the form of oil of phosphorus, but not in concentrated form. Neither phosphorus or antimony has been tested for as long a time as arsenic and it is necessary before adopting them to gain more experience in regard to their action. Wunderlich recommends iodide of potassium and for an after cure iron preparations and iron baths.

Recently Dr. Coley has used with some success the mixed toxin of streptococcus and bacillus prodigiosus. He begins with the injection of one fourth of one minim and increases to four minims, or until a reactory temperature of 102 to 104 is reached. The injections are made into the tumor masses themselves preferably, but when this is not practical, in the cellular tissue anywhere on the body. The injection is given each day if too much depression is not experienced, otherwise two or three days intervals are observed.

#### DISCUSSION.

DR. C. C. NESSELRODE, of Kansas City.—I was very much interested in the doctor's paper. He didn't state the date of this patient's death.

DR. MANNING: He lived two and a half years from the date of the first examination, and died, I think it was in October a year ago.

DR. NESSELRODE—I was also very much surprised at the reported blood count, for although the man was then cachectic and died in less than two months there after we have reported a red count slightly above normal and haemoglobin 80%.

The white count of 51000 is certainly not a part of the picture of Hodgkins' disease, and if this was an accurate count we will have to look for something foreign to the disease to explain this leucocytosis. Perhaps it might be charged to the sloughing tonsil to which the author refers.

The usual blood picture of so advanced a case of Hodgkins is the picture of an advanced secondary anemia, perhaps two or three millions reds 30 to 40% haemoglobin and two to five thousand whites.

While this case from its clinical aspects would perhaps justify a diagnosis of Hodgkins yet the diagnosis of Hodgkin's disease is never a certainty until a section of the pathological tissue has been examined with the microscope; for while there is nothing essentially characteristic in either the clinical history or the blood findings of a case of Hodgkins yet it has as definite and characteristic a pathological histology as has a tubercular lesion or carcinoma.

And since no autopsy was done or no microscopical examination of the tissue made we are inclined to accept this as a probable diagnosis and not as a positive one.

DR. MANNING, (Closing the discussion).—I have not very much to say. My excuse for writing this paper was because of the rarity of the disease, being the second one I had ever seen. The first one was in St. Luke's Hospital, Chicago eight years ago, when I was an interne there, and I was interested at that time, and took occasion to look up the literature, and this came to me after it had gone around for some time, and had been diagnosed various ways, and I made a study of it for a good many months before I was satisfied as to what it was. One of the things that struck me in beginning to prepare this paper was the lack of definite know-



ledge that could be gained from all the articles on Hodgkin's disease. Every one that has written has written about the same thing with about the same kind of definition to it. Coley is a man that has written quite a little on Hodgkin's disease, and his trend is entirely toward that of lymphosarcoma. He does not really consider it a disease differentiated in itself.

Concerning the criticism on my count of the leucocytes I want to state probably that was caused on account of the condition of the tonsil in this patient. It was sloughed out at the time I made the count, and probably the number could be accounted for in that way.



## THE GASTRO-INTESTINAL NEUROSES.

By DR. W. R. HEYLMUN, Iola, Kansas.

Read Before the Kansas Medical Society, May 7, 1908.

Disorders depending on a disturbed or deranged condition of the nervous system, without an organic lesion, or in no wise dependent on an organic lesion, are among the most common of ailments, ranging all the way from transient emotional disturbances to the most profound invalidism.

In the more pronounced disorders coming under this head the symptoms are usually complex, and often extremely puzzling to the physician. The question as to whether or not he has to deal with a purely nervous affection is often most difficult to solve.

Between the mild disorders of the nervous system and the pronounced cases of neurasthenia there is a middle ground, made up largely of those neurotic persons who often go the rounds of the doctors, healers, spiritualists, etc. It is among this class that we find those sufferers from gastro-intestinal neuroses with whom this paper has to deal.

Among the multiplicity of subjective symptoms belonging to nervous disorders, a few are present in nearly every case, from the mildest to the most severe. These are: head-ache, insomnia, and some form of gastro-intestinal derangement. It would hardly do to say some form of gastric, or maybe, intestinal derangement, because the stomach and intestines are nearly always associated in the disturbance, although the patient may complain more of one organ than of the other. The head-ache, insomnia, and gastro-intestinal disturbance are often variously combined in the same individual.

The neuroses affecting the gastro-intestinal tract are commonly divided into three classes, viz: motor, sensory, and secretory.

The motor neuroses of the stomach are, 1st: regurgitation of food; 2d: a relaxed sphincter of the pylorus during the process of digestion, which permits food passing before it has been properly

acted upon by the digestive juices. This condition has been called by Boaz: "Incontinentia Pylori". 3d: nervous eructation, which is usually the expulsion of air from the stomach, with a small admixture of gas. 4th: flatulent distention, in which the stomach is markedly distended with air. 5th: the peristaltic unrest of Kussnaul, in which abnormal peristaltic movements of the stomach and intestines occur almost continually, without reference to the ingestion of food. This movement is accompanied by uneasiness, often amounting to actual pain.

The sensory neuroses include, 1st: morbidly increased sensations of hunger, or, on the other hand, entire loss of appetite, accompanied by a loathing or disgust for all kinds of food. 2d: nausea, with or without vomiting, even when the digestive apparatus is not at fault. 3d: gastralgia, which may be severe and periodical and independent from ingestion of food. 4th: stomach burn, which has no connection with the ingestion of food, and differs essentially from heart-burn.

The secretory neuroses of the stomach include those cases where no organic disease exists, and yet there is a marked deficiency in the gastric juices, the "Achyilia Gastrica" of Einhorn. In other cases there is a hyperacidity, due to an excess of normal hydrochloric acid secretion.

In what is commonly known as nervous dyspepsia the symptoms of motor, sensory, and secretory derangements are usually variously combined, and produce a complex set of symptoms which are often most difficult to rightly interpret.

Nervous derangements of the intestines, like those of the stomach may be divided into motor, sensory, and secretory. The disorder affecting the stomach may extend to and affect the intestine in the same manner.

The motor neuroses of the intestines include, 1st: peristaltic unrest, which causes more or less uneasiness, often amounting to actual pain. In this condition the peristaltic motion is often reversed at intervals so that the intestinal contents are not moved along quietly and continuously as in health. 2d: paresis and paralysis, which affect the large intestine only. 3d: nervous flatulence, similar to nervous eructation. The sensory neuroses: about all that comes under this head is enteralgia, a painful irritation of of the intestinal nerves, occurring without apparent anatomical cause, and classed as a true neuralgia. The secretory neuroses include those cases in which there is a marked excess of intestinal secretion producing what is known as nervous diarrhea, or on the

other hand, a greatly diminished secretion, leading to obstinate constipation.

While gastro-intestinal neuroses are found among people of all ages, and both sexes, yet the most numerous sufferers are found among females between the ages of twenty and fifty. It is during that period of life when the cares, worries, and responsibilities are greatest, that these disorders most frequently occur. They are not peculiar to the refined, æsthetic, society-going class, those of opposite tastes and environments being equally subject to such derangements.

The victim of a well pronounced nervous disorder is a sick person; he can no more remedy his condition by the exercise of will power than he could rid his system of malaria by such means.

Some of these disorders like peristaltic unrest, flatulence, etc., by their continual annoyance, have a disturbing effect on the whole organism, as a sore corn, unrelieved, will eventually develop a case of nerves. This constant nervous disturbance of the digestive apparatus has a very depressing affect on the mind of the patient. He is disposed to greatly magnify his symptoms, imagines that he is much worse than he really is, and many such patients live in constant dread of a fatal ending, the result of a disease that has no existence. The gastro-intestinal contents not being cared for in a normal manner is doubtless the cause of more or less auto-intoxication, which still further aggravates the trouble.

When we endeavor to trace these disorders back to their origin, and locate a place where the nerve forces have gone wrong, we are working in the dark, as very little light has been thrown upon the disturbed processes that are responsible for them.

Before considering some of the possible causes it is necessary to first study the nerve supply of the organs under consideration. The nerves supplying the stomach are the right and left pneumo-gastric, and branches of the sympathetic, derived from the solar plexus. The intestines are supplied by the sympathetic, and it is claimed by Pal and others that the entire intestinal tract receives motor fibres from the pneumo-gastric. According to Bechteren and Mislawski, the acceleratory stimulus of the intestines passes through the pneumo-gastric, the inhibitory, through the spinal cord. In the various nervous disorders of the stomach and intestines, the trouble arises at some point in the pneumo-gastric or sympathetic system; or it may be that both systems are involved in the disorder.

In neurasthenia there appears to be a weak condition of the

nerve cells in general, and they are unable to supply enough nerve force, or dynamic energy, to keep the system in a normal working condition.

In the various neuroses the symptoms do not indicate exhaustion of nerve cells, with a consequent diminution of nerve force so much as they do nerve force gone wrong, or not properly distributed or inhibited.

I am of the opinion that when the stomach and intestines perform their functions in a thoroughly normal manner, the pneumo-gastric and sympathetic nerves must work together in perfect unison, like a musical instrument in perfect tune. If one of these nerves fails to do its part then there is discord and deranged function.

The subjects of these nervous disorders are persons who are so predisposed that they are usually the unfortunate possessors of an unstable nervous system, transmitted to them by hereditary; still, to develop a true neuroses, a factor must be brought to bear that previous to such development did not affect the individual. We can only speculate as to what this factor might be. Possibly it is the fatigue toxin of Weichart in the blood, which even in small quantities has a bad affect on some of the nerve centers; or it may be that there is an absence of something in the blood essential to the normal activity of these centers.

E. Schneider, in the New York Medical Journal of November 6th, 1907, states: "That certain facts have recently developed which suggest that supra-renal insufficiency may produce the phenomena common to neurasthenia, also digestive troubles, including anorexia, vomiting, diarrhea, and peritoneal symptoms."

A protracted, troublesome neurosis of the digestive organs may be due to a reflex nerve disturbance, originating in some remote part of the body, such as eye-strain, loose kidney, disease of the generative organs etc.

In just how far a local organic trouble in the pelvis or some other part of the body can be held responsible for a neurotic condition, cannot be satisfactorily determined without first removing or remedying, the defect.

A statement recently made by Robert T. Morris touching on this subject, and a reply by Dr. Frank P. Norbury, of the Maplewood Sanatorium. are both pertinent to questions that might be proposed at this point.

Dr. Morris says, in speaking of the treatment of these nervous patients at sanitariums: "Are there many in which the physicians make more than a shallow pretense of finding the real cause of a



neurasthenia? Do they look for eye strain, loose kidney, or involuting appendices, and the various well known leaks below the water line? Not at all! They depend upon the psychic influences of the environment for getting up the patients steam, or filling his sails."

In reply to Dr. Morris, Dr. Norbury says: "Are there many surgeons who proceed to study the real clinical psychology of their patients with a hope to find somewhere in the field of consciousness the mental perversion, the obsession, which in itself is the disease, and not the localized phenomena, of which pain, anorexia, etc., are the prominent symptoms." Speaking of surgical interference as a means of relief in such cases, he adds: "Not only is it profitless, but adds to the burdens of such an unfortunate one, whose diverse mental states are already wafted by the currents and counter-currents of self-consciousness. And not infrequently the surgical interference is the one necessary straw with which to break, perhaps forever, the patient's back."

The foregoing helps to prove the statement before made that a local disease may be associated in the same individual with a gastro-intestinal neuroses, without being responsible for it.

The diagnosis of the gastro-intestinal neuroses is arrived at largely by the process of exclusion. Some of them simulate organic disease so closely that they test the physician's skill to the utmost in making a correct diagnosis. Still, the behavior of most of them is such, in some essential particular, that he is enabled to exclude the organic disease which may be imitated. Gastric catarrh, and other organic diseases of the stomach, are recognized by symptoms which are aggravated by the ingestion of food, especially certain kinds of food, while in nervous derangements of the stomach these factors seldom have a bad effect, often, on the other hand, giving relief to some of the distressing symptoms.

In spite of the differential factors by which we are usually enabled to distinguish nervous affections of the alimentary tract from those of an organic nature, by the usual routine methods, carefully carried out, there are some cases in which the symptoms are so confusing that to get at a satisfactory understanding of the case it will be necessary to give a test meal, withdraw some of the contents of the stomach, and subject them to a chemical, and possibly a microscopical, analysis.

Some of the points that count for a good deal in making a diagnosis are: the personality of the individual; his build, age, habits, and the manner in which he talks about and describes his

symptoms. As to build, he is likely to be found well nourished, in spite of the long period of suffering which he claims to have passed through, this being obviously impossible had his condition been as bad as he imagined, or had it been due to organic disease.

These gastro-intestinal neuroses are essentially of a chronic nature, and while there are times of apparent improvement, these are offset by periods of relapse. The prognosis, therefore, must depend upon a number of elements that enter into the problem. If the disorder continues on from year to year, anatomic changes are likely to take place sooner or later with the development of a true gastric catarrh. If the patient is so situated in life that he can, and will, pursue the most desirable plans for his betterment that his physician can advise, then his recovery can be almost assured; but if he is so situated that he must remain at home, follow his usual vocation, surrounded by the same environment, and depend too much on drugs, the outlook as to a final cure is not very hopeful. However, the prognosis must be modified when the condition is found to be due to eye-strain, or some organic disease that can be remedied by surgical measures or otherwise.

While, in the various neuroses, certain methods of treatment are indicated to meet certain indications, there are a few general methods applicable to nearly all cases. The first and most important step in the treatment is to determine as to whether or not the trouble is purely functional. Refractive errors should be looked after, and corrected, if found; and while such correction may not cure the trouble, yet it will aid in effecting a cure by removing a disturbing factor. If an abdominal or pelvic trouble is found, or any "leak below the water line," it may require surgical interference, but, in my opinion, no more interference than would be justified if the neurosis did not exist. The habits of the patient should be carefully investigated, and everything that might be detrimental to his health corrected, if possible. Inquire as to the kind of food he eats, and whether he masticates it properly? Does he take as many hours for rest and sleep as he should? His sexual habits should be enquired into, as they may be the source of the disturbance. Having been able to exclude any organic trouble, to correct eye-strain, if found, and to secure the patient's assistance in the regulation of any deleterious habits, the next important step to consider is change of environment. This means that the patient should get back to conditions calculated to stimulate the various physiological functions; back to the woods, the fields, the mountains, and perhaps to the sea-shore—back far enough,

and long enough, to give the system a good opportunity to recuperate. While a change of life will not cure, it acts as an alterative tonic, giving the inherent forces of the patient the most favorable opportunity for regaining their normal condition. Everything that is calculated to build up the strength of the patient, and add to his vitality, leads him in the direction of greater nerve stability and effects the harmonious working of the perverted nerve centers. As to diet, it has been my experience that no hard and fast rules can be followed in these cases; so experimentation is required and is justifiable; every case of gastro-intestinal neuroses is a law unto itself as to the most appropriate diet. The patient should be nourished as much as possible, and it will often be found that food of which he was fearful can be eaten without any increased discomfort. It is often imagination that makes the patient afraid to try certain kinds of food, and if he is persuaded into a trial of such food, it may be that it is only through the imagination that he feels the worse for it. This fear can often be overcome by tact and encouragement on the part of the physician, because it is often purely imaginary. Medicines are often used to advantage to meet certain indications. Hyperacidity requires alkalies, such as bicarbonate of sodium, etc. Hyperperistalsis, and peristaltic uneasiness of either stomach or intestines, require the bromides, valerian, and other nerve sedatives, which usually serve a good purpose. Atony requires strychnia; anorexia, bitter tonics; gastralgia, during periods of rest, valerianates, iron, and arsenic—during the attack, hypodermics of morphine and atropine. There are few cases of nervous derangement, affecting either the stomach or intestines, but what will be benefited by the persistent use of tonics.

In speaking of the treatment of nervous dyspepsia, Anders says: "It is the nervous system that demands especial attention, and the internal treatment of the stomach is merely placeboic."

Persons who have been afflicted with a neurosis of the stomach or intestines for a considerable time, are apt to become more or less hysterical, morose, and despondent. Their imaginations magnify and add to their symptoms. They find it difficult to think of anything but themselves; they would rather talk about their bad feelings than anything else. Now, in my opinion, suggestion, as a remedial measure, will not cure the underlying nerve defect, but it often helps in a great degree to overcome the bad effects of the imagination, and helps to return the mind to a proper estimation of the real symptoms, which may not be so intolerable after all.

Boaz, speaking of the treatment of some of these functional nerve disorders, says: "We often learn from the failures of the patients what we should not employ, and, however paradoxical it may sound, that physician has the highest trump in his hand in the treatment of the neurasthenic in general, and of the nervous dyspeptic in particular, who treats them as the last."

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## GUNSHOT WOUND OF ABDOMEN.

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By DR. W. S. GRISEL, Ransom, Kansas.

Read Before the Kansas Medical Society, at Iola, May 6, 1908.

In considering the question of care and prognosis in a given case of gunshot wound it is necessary to take into account, not only the location and apparent extent of the injury and general condition of the patient, but also the kind of weapon which inflicted the wound, the character of the missile, the range at which it was fired, and whether or not it passed through the patient's clothing before entering the body. This paper does not purport to touch the subject as it presents itself to the military surgeon, but we confine our observations wholly to the question as it presents itself to the general practitioner—the accidental injury which any of us may encounter at any time.

It is obvious that a shot fired at long range will not produce the same destruction of tissue and sloughing that it will produce if the weapon is in close proximity to the body.

Again, a missile which first passes through the clothing is likely to carry foreign matter and infection in with it while one which enters an exposed part of the body is not so likely to carry in either. As the abdomen is not apt to be exposed at times when accidents are likely to occur, (that is among civilized people and white folks generally), we have this danger from foreign matter and infection in most gunshot wounds of the abdomen, especially from a large bullet or charge of shot. The likelihood of serious lesion of some of the abdominal viscera however presents by far the greatest danger in this class of injuries and this danger is greater in wounds on a level with or below the umbilicus than in those higher up owing to the gravitation of the viscera to the lower part of the abdominal cavity in the erect posture, in which posture most such injuries are received. The vomiting of blood after a gunshot wound of the abdomen, our text books tell us,



is an indication of puncture of the stomach. However this is not conclusive evidence that the wound is mortal. I recall a case I saw with Dr. J. E. Attwood of Utica, Kansas, a few years ago: a man about thirty-five years of age who shot himself in the epigastrium with a 22-calibre rifle.

The ball ranged almost directly backward and a hard substance, evidently the ball, could be distinctly felt near the median line on the back. The normal position of the stomach lay in range with this hard substance in the patients back and the wound at which the bullet entered the body.

The patient was in such pain that he required an opiate, and he vomited a coffee-ground material which we decided was blood a few hours after the accident. The patient was sent to the hospital and I afterwards learned that he recovered without laparotomy, but I never learned whether or not the bullet was found in his back.

The following case occurred in country practice: J. P. Male, Age 16. White. Large and well developed. Family history and habits good.

On April 30th. 1907 at one o'clock P. M. he accidentally discharged a 12-gauge shot gun loaded with No. 4 shot at a range of from six to twenty inches from the body, the load passing through the middle finger of the right hand one-half inch from the metacarpo-phalangeal articulation severing the finger almost completely, lacerating the palmar aspect of the thumb and fracturing the first phalanx.

The back of the hand was burned and blackened by the explosion. The load entered the abdomen two inches below and one inch to the right of the umbilicus ranging upward, backward and a little to the right.

Dr. F. D. Fagan of Brownell, Kansas, and myself were summoned and arrived about one and one-half hours after the accident. The patient had vomited a suspicious looking coffee-ground material. His general condition was fair and he was in good spirits.

In lieu of anything better we sterilized towels, sheets, instruments and dressings by boiling them in an ordinary wash boiler, used the kitchen table for an operating table and made an exploratory incision from the external wound upward.

We found not to exceed a dozen shot in the clothing, abdominal wall and peritoneum and there were also several pieces of clothing lodged in the abdominal wall. There were three openings in the peritoneum, one above another, at about the level of the umbilicus, through which the bulk of the load had evidently entered the

abdominal cavity, and passed beneath the pylorus and to the left of the duodenum.

There were several shreds of clothing in the abdominal cavity and the omentum was considerably torn, necessitating the removal of a considerable portion of it. The posterior margin of the liver could be felt, rough and was bleeding some. There were a few small ecchymoses on the small bowel but no punctures. We found none of the shot which had entered the abdominal cavity. The abdominal cavity was irrigated with normal salt solution and closed. A small gauze drainage was introduced into the external wound which was then closed with silk.

The finger was removed, the hand dressed and patient put to bed and given a hypodermic of morphine  $\frac{1}{4}$  gr. and atropine one one hundred and fiftieth gr. A liquid diet was ordered, Also strychnine one-fourtieth gr. four times a day. There was some nausea the second day but no serious symptoms. The third day the nausea was less marked. The wound was dressed and the bowels moved with glycerine enema. On the afternoon of the third day the discharge became offensive and temperature rose slightly. Pulse went to 125 and became unsteady. A tablet of nitro-glycerine compound (De Costa) was given every three or four hours and the symptoms began gradually to improve. The bowels became loose after the third day and remained so until the eighth day when there was some gaseous distension of the abdomen, but no tenderness perceptible. On the eleventh day the nitro-glycerine was stopped and strychnine given again. About the fifth or sixth day the patient complained of tenderness in the muscles of the left leg. This became more marked in a day or two with swelling and redness extending to the middle of the thigh. The leg was bathed with laudnum and dressed with cataplasma kaolini and the swelling and pain soon disappeared.

There was considerable sloughing around and above the external abdominal wound, but the patient was able to sit up in six weeks, and convalescence was uneventful though tedious.

This case proves to my mind that vomiting of coffee-ground material after gunshot wound of the abdomen is not conclusive evidence of puncture of the alimentary canal. It also convinces me that the patient's family and personal history and habits are all-important questions to consider in giving a prognosis in this class of injuries.

DR. L. H. MUNN, of Topeka—There is probably no subject that comes up to the general practitioner or the surgeon of more importance than these cases of belly injury. Whether you have a well defined perforating wound or whether you have the evidence of contusion as the result of a fall, what should be your duty? I have opened the belly of men vomiting blood, expecting to find a perforation of the stomach and found none. I don't believe I made any mistake in doing it. How will you know when to open the belly. I don't know of anything that has tried me more than that proposition. There are only a few high points that can govern you in your coming to a conclusion what you should do. I take it from the doctor's report he didn't open the peritoneal cavity. He has not given us any high point on this man. A man cannot suffer from any injury, he cannot suffer from any pathological condition but he will give you somewhere some high point. Now this man, there are only two or three things and they are conclusive and definite. A man has received an injury to his belly by a kick or a fall or a load of shot, and the first proposition "Is the man sick?" If he is sick he will show it. By checking up his pulse and other symptoms you will decide the man is sick. You have not shown us this man was sick for the purpose of argument. There is only one other thing that governs me; suppose he has got a perforating wound, we cannot inject hydrogen, we cannot wait for him to have general peritonitis; if that man has received any injury of his abdominal cavity there is just one thing I have found always present, and that is muscular fixation. If the man is sick he has got muscular fixation; open his belly and you have done your duty by the man. If he has not got those high points let him go, whatever the injury be.

DR. JONES—I would like to ask the essayist what his idea was in giving strychnine the next day after receiving the injury. I am asking for information because it has been my plan always to regard anything of that sort as a menace to my patient. In many of those cases of gun-shot wound of the abdomen, I think it might be well to take into consideration the social status of the patient. The ordinary rounder who has lived under most un-hygienic conditions all his life will tolerate a great deal more infection than the ordinary man who rarely gets such an injury. So as a general thing the man whose life it is most essential to the community to save is one of the hardest lives we have to save from a gun-shot injury. The man who has lived in squalor all his life will tolerate injuries to the abdominal viscera, including the kidneys, very much better than a man who is in the real pink of physical condition.

I agree entirely with Dr. Munn as to the necessity for going into these abdomens whenever the injury is sufficient to warrant the belief that there has been severe injury of a viscera. We should not wait for evidences of peritonitis; and another thing in connection with that is the fact that these injuries to the viscera are comparatively free from danger up to certain number of hours after the operation because peristalsis is absolutely paralyzed, and injury to the large bowel rarely lets anything escape except a laceration. A gun-shot wound rarely sets up a very great peritonitis for several days. An injury to the small bowels, the contents of which are always fluid, will set up a more immediate resistance on the part of the peritoneum, but still you have a few hours of safety in which you can enter the abdomen.

DR. LIGGETT, of Oswego—I believe Dr. Munn spoke about the high points in bowel injury. It seems to me there need be but one point in these gun-shot wounds, that is the fact of perforation makes it imperative that the bowel be opened at once; if you wait until you determine that something has happened inside, you have waited until you had better let your patient die a natural death, because the majority of them will die even if you do have an operation. It is in those cases of injury to the abdomen that do not penetrate that puzzles the ordinary physician and sometimes the surgeon. What symptoms can the surgeon give to the general practitioner that teaches him when he shall call the surgeon? Many times a man receives an injury to his abdomen and is not much hurt, and

again the very mildest of blows will produce death. I have in mind a case I saw where a horse in kicking out sideways jerked a clip off of the single tree and it swung around and hit a man in the belly, and he died in 10 days. How could the doctor in attendance tell that man's bowel ought to be opened within a few hours after the injury. After peritonitis sets up it is too late to do any good. What can he go by? The three points I have learned to depend on are, first: Pain, lasting longer than an hour or two, longer than the injury would warrant if it was in another location; second, shock with the signs, the facial appearance, quick pulse, etc; and third, and most important is the one, muscular rigidity. If you have pain, the least evidence of shock and muscular rigidity you certainly should open that belly at once. If you find you are mistaken you have not done the man much harm, if you do a good job.

DR. GRISEL, (Closing the discussion)—I would say, in the first place, that Dr. Munn misunderstood me. I said I did open the abdominal cavity and found the conditions described inside. In regard to the patient's being sick and having muscular rigidity, this patient had both. He had vomited I think two or three times immediately following the accident before I arrived, and there was considerable muscular rigidity and no marked failure of the pulse, it was reasonably good, considering the injury; but, as I say, the incision was made somewhat as an exploratory incision for the reason that the doctor just remarked if we waited—this patient was in the country five or six miles from any physician, I was the only one at that town, and the other physician at another town—it would be quite an undertaking for one physician with no skilled help at all, and under the circumstances which we had, which the city physician does not appreciate—we took the view that it would do the man no harm if it was done properly and it would certainly be almost criminal to leave a patient with a probability of visceral injury without giving him all the reasonable means of determining what the injury was. We also found, while there was no injury to the intestinal canal that required closure, it was very seriously lacerated and a considerable portion of it removed, and in the future care of the patient, the sloughing which occurred in the subcutaneous tissue convinced me thoroughly that had not this portion of the peritoneum been removed it would certainly have sloughed too and in that case I could see no other than a fatal issue.

I also recall an experience I had a few years before of a man 40 years old, fell on a barge used for hauling stone, what we call a trifling injury of the abdomen a little below the navel and in a day or two he was up and out walking around in the yard at four o'clock in the afternoon; at 7:30 I was summoned and drove out two miles and found the patient dead, so this experience made me very solicitous as to the conditions inside.

The object of giving strychnine in this case was to sustain the circulation and prevent shock. There being no perforation we didn't consider that a reasonable amount would be in any way injurious.

I would also thank the doctor for his especial emphasis of the danger of expectant treatment. I don't believe it is the thing. If it is followed for a day or two until general peritonitis has set in he had better let the patient die a natural death and save his own reputation.



## TREATMENT OF FRACTURES OF THE LEG.

By DR. G. P. MARNER, Marion, Kansas.

Read Before the Kansas Medical Society at Iola, Kansas, May 7, 1908.

Probably it should be deemed presumptuous in a County Doctor to attempt to write a paper of any value to the members of this society on so important a subject as "Treatment of Fracture



of the Leg." I trust you will regard the paper rather as an introduction to a subsequent discussion in which we may all hear the experience of individual members. I admit at the start that the paper is rather rambling, but you surely will overlook this, when I also tell you at the start that it is short.

For the treatment of fractures of the leg Scudder classifies: 1st. Fractures with little or no swelling or displacement. 2nd. Fractures with considerable swelling. 3rd. Fractures with a displacement of fragments difficult to hold corrected, and 4th. Open fractures. The indications to be met by treatment are correction of deformity, immobilization of the parts and restoration of the limb to its normal condition. To meet these indications successfully, it is necessary to have a clear knowledge of all the pathological conditions in each case. If one is able to find all the lesions which are present in a given case, a Potts fracture is not near so nerve racking. This fracture is usually spoken of as an injury from which perfect recovery is not to be expected but my notion is that with a reasonably good knowledge of all the lesions and well applied suitable splints, a good result may be expected.

The lesions in this break, as we all know are rupture of the internal lateral ligament, fracture of the tip of the internal malleolus, a separation of the lower tibio fibular articulation, a fracture of the fibula two or three inches above the external malleolus, and a fracture of the outer edge of the lower end of the tibia, and if the force continues, the fracture may become an open one by pushing the internal malleolus through the skin.

These lesions permit a backward displacement and eversion of the foot by allowing the tendo Achilles to draw the foot backward, while the lack of support on each side allows the muscle (peroneal) to hold the foot in position of eversion and outward displacement.

Of equal importance to a knowledge of the pathology in a case of fracture of any part of the leg, is the question of splints. Ill fitting, unsuitable, and poorly applied splints, are the causes of more annoyance and bad results than all other defects combined. Splints should be reasonably firm, easy of application, and of such shape as will place the leg in as near normal position as possible and give the patient as much freedom as is consistent with safety.

In my own practice I have had very good results with a posterior wooden splint, which I have devised something after the plan of Esmarch double incline plane, but it is much more simple, costs less, and has the additional advantage of being so arranged that traction and counter traction can be had, and the patient can be

taken out of bed and be allowed to sit on a chair or lounge, and can be transported if necessary.

This splint as can be seen from the photograph is universal, can be used for a youth and the tallest adult. The wide upper end prevents turning over, and the opening at the lower end gives place for the heel to rest in, and it gives just enough flexion at the knee to give the patient the most ease.

Considerable attention should be paid to the padding of splints, according to the normal curvature of the leg, and all pressure must be kept from the heel. Scudder lays great stress on this point. His favorite splint is Cabots posterior wire splint. This splint answers very well, but has the disadvantage of having to be made for each patient, and is not the easiest thing made, and has no provision for traction and counter traction,

In fractures with little or no displacement and swelling, the treatment is simple, unless there are oblique fractures of both bones; in such an event there is liable to be shortening, which can best be prevented by traction. Traction also assists in keeping the fragments in place and is a great help in lessening pain. Side splints can also be used either with the splint I have described or Cabots wire splint, but the leg should not be so enclosed with splints and other dressing that inspection anteriorly and laterally can not be had at any time without disturbing the principal splint.

In fractures where there is considerable immediate swelling, all tight dressing must be avoided. The limb should be thoroughly cleansed with soap and water, afterwards washed with a bichloride solution, then dried and powdered, and the limb laid in a posterior splint, till the swelling partly subsides, then more attention should be given to reduction and permanent dressing.

Fractures with displacement of fragments difficult to hold reduced are usually oblique of both bones, the nearer the break is to the angle, the more difficult to hold reduced. They can be treated best by traction and side splints in addition to the posterior splint.

Open fractures are nearly always infected, at least should be treated as such. They should be thoroughly cleaned and disinfected according to the best known methods, except in joints. I would hesitate to wash with a bichloride solution as a synovitis might be caused which would do more harm than the original infecting material. In some instances it may be necessary to enlarge the wound and suture the fragment, but great caution is necessary in this procedure, the danger of infection is very great. When in doubt in such a case I believe it is the best practice to

give the patient the benefit of the doubt, establish free drainage, put the leg in a firm splint, and arrange to dress without soiling and disturbing the splint and padding, which can be easily done with the posterior splints described.

Potts fracture can, I think, be treated best by placing the leg in a normal position, viz: knee slightly flexed, and foot at right angle with leg placed in a posterior splint, and if the fracture is compound, dressing and padding so placed that the wound can be cleansed and redressed without disturbing the splint sufficient to move any of the fragments.

When sufficient union has taken place in any of the different fractures of the leg so that it can be safely handled, a plaster of Paris splint can be put on with advantage, and the patient allowed to go about on crutches. But for a first and permanent dressing, I believe it is far inferior, more troublesome and dangerous, and annoying to both patient and physician, than the solid posterior splint.

In conclusion I will quote again from Scudder. "The first night after putting up the fracture the patient will probably be uncomfortable. The new and restrained position, the after effect of the anesthetic, if one has been used, the splints of undue pressure yet to be adjusted, the itching of the skin, the inability to move about, the necessity of lying in one position, actual pain at seat of fracture, all combined to make life miserable. It will be a wise precaution on the part of the attendant if a little morphine is administered, subcutaneously first night, as the patient, nurse and physician will rest better."

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DR. J. G. SHELDON, of Kansas City—This interesting and practical paper brings up a great many points. The splint is a good one, but there are a great many ways of dressing fractures. In some of these fractures where it is not advisable to put on a cumbersome dressing, a very good splint may be made by rolling plaster of Paris on a table. Here is one made for a girl's wrist which is very light but can be made as strong as one wishes, made by rolling a plaster of Paris bandage on the table and the plaster may be applied and molded to fit accurately. The great advantage of it is, it can be placed next to the skin without any particular trouble and hold most any sort of fracture in the desired position. It does not interfere with the circulation.

In the treatment of compound fracture, it seems to me it is well to divide them into two classes, those due to direct violence, and indirect violence. If the force has been applied some other place than the site of the fracture I think it is a great mistake to open that wound and clean out all the lower part for the reason that as the bone has been pushed from within outward the chances of infection is less if it is simply cleaned on the outside than if it is opened up widely. This rule will not hold good in a compound fracture due to direct violence. Then the foreign and dirty material probably has been thrown deeply into the part and cleansing is necessary. In regard to Pott's fracture, I believe most of these fractures ought to be dressed in inversion. I believe this manner is better as long as it does not spread the tibia and fibula from each other.

DR. MARNER, (Closing the discussion)—I have nothing further to add except one word in favor of the splint that is the ease it gives the patient, the slight flexion of the knee seems to add considerably to the ease of the patient. If you lay the patient straight he soon gets nervous; if you doubt this, just lie in bed with your own leg straight for an hour. You will not stand it that long; and the moment you put the patient on this splint he is at ease.

Now in regard to what the gentleman says to treating at right angles. Pott's fracture can be dressed with the inversion by simply padding the splint enough to bring the heel out at the base and putting a triangular plug against the boot. I had a case of Pott's fracture and I never saw better results than I got in that. In a few days after the patient got over the first restlessness it seemed the leg relaxed and we got a perfect result.

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## ACUTE GLAUCOMA.

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By DR. J. G. DORSEY.

Read Before the Southwest Medical Association, Wichita, Kansas.

Priestley Smith says "Acute primary glaucoma is frequently mistaken by unskilled persons for an ordinary inflammation of the eye, and erysipelas or a neuralgia attack. This mistake is disastrous, for it leads to irreparable loss of sight.

This is excuse enough for writing upon this much discussed subject. The best way I know of to stop these mistakes is to bring before the profession the facts of the case so often that they cannot forget them.

Until 1709 when Brisseau showed that glaucoma was not a disease of the lens, and attributed it to opacity of the vitreous, glaucoma and cataract were often confounded and by many considered identical diseases.

1830 Mackenzie noted the hardness of the globe in this disease and practiced puncture of the vitreous for its relief. This observation was little noticed at the time and it was not until 1854 that it was really utilized, by Von Graefe, who rediscovered it and in his efforts to relieve the condition gave us iridectomy as its cure.

Von Graefe held that the disease was caused by a serous choroiditis which produced increase in the volume of the vitreous, rise in intraocular pressure and compression of the retina, and most authors add to this what to some would seem to be the results of such an inflammation; that is the blocking of the filtration angle of the aqueous from various causes and the changes in the aqueous that hinder its easy filtration through the canal of Schlemm. Stelwag held that the cause lay in a hardening of the sclerotic coat together with an atheromatous condition of the walls of the blood vessels. He also in a measure foresaw the theory of Zimmer-



man for he says "In many cases general disturbances in the circulation—for example, temporary increase of the cardiac pressure or slight obstructions in the region of the superior vena cava—may be the proximate cause, since they propagate themselves to the internal vessels, but can not be compensated for rapidly enough on account of the abnormal relations and hence remain permanent."

Notice the resemblance—Darier says "According to Zimmerman, glaucoma is due to a disturbance of the equilibrium which should normally always exist between blood pressure and intraocular tension." "Briefly, in one way or another, the blood pressure being lower than the ocular tension, the blood wave conveyed by the retinal artery has no longer the force necessary to overcome the resistance opposed to it, and this is especially the case because of the angle formed by the artery on entering the retina. It is then that one sees an arterial pulse in glaucoma on examining the eye with an ophthalmoscope."

"Retinal ischemia is thus induced, the nutrition of the capillaries suffers, lymphocytes transude, and the exudation of serum brings about a kind of oedematous infiltration, which helps in its turn to raise the intracocular pressure. As regards the ciliary processes, the filtration is the more marked as the long ciliary arteries traverse the sclerotic without making angles; the blood supply would take place more easily than for the retinal arteries. On the other hand, the ciliary veins with their fine walls are compressed by the excess of intraocular tension. From all this there comes about a ciliary hypersecretion, and then a swelling of the entire ciliary body, which compresses the irido-corneal angle etc."

Priestley Smith says "Primary glaucoma appears usually to depend on some vascular disturbance which congests the uveal tract, or upon a faulty relation of the lens to the parts around it, or upon both "and adds "An obstruction in the region of the hyaloid and the circumlental space, which checks the escape of surplus fluid from the vitreous and leads to an advance of the lens appears to be present in many cases."

All authorities agree with the statement of Priestley Smith that "The common antecedents of glaucomatous attacks are, exposure to cold and damp, fatigue, hunger, loss of sleep, depressing emotions, constipation, hepatic derangement, heart weakness, bronchitis etc." In short, various conditions which disturb the circulation and congest the venous system "and that they are benefited by the things that relieve these condition such as warmth, rest and purgation."

Darier says "Glaucoma is due to a sudden increase of the intraocular tension, provoked probably by a reflex vaso-dilator action which upsets the balance of the nutritive intraocular exchanges."

Ball gives as direct causes, "grief, anxiety, worry and the loss of sleep" and says "It should be defined as a disease of the sympathetic nervous system producing increased intraocular pressure."

He therefore embraces the nervous theory of Abadie, who holds that the disease is due to excitation of the vaso-dilator nerves through the sympathetic.

Knies and Weber hold that the disease is the result of glueing together of the irido-corneal angle and the blocking of the canal of Schlemm.

Pathologically in the acute variety the uveal tract shows congestion of the veins with hemorrhages.

The tissues are swollen by exudates containing fibrin, leucocyte red blood corpuscles etc.

Birnbacher & Czerniack describe changes in the vortex veins.

The perivascular lymph-spaces and the surrounding sclerotic are infiltrated with round cells, and round and oval cells pervade the vessel walls.

The iris gives evidence of acute congestion and there is usually a tendency to closure of the filtration angle.

E. Von Hippel says that in acute glaucoma there is marked obliquity of the outer limbs of the rods and cones and that they are directed away from the fovea.

The optic nerve becomes cupped or depressed partly from the effects of pressure and partly from degeneration of the ganglion cells in the retina from which they spring.

The changes in the sclerotic are those to be expected from high pressure from within the eye: namely stretching and ectasia.

The periphery of the iris becomes adherent to the cornea blocking the filtration angle.

#### SYMPTOMS.

Prodromal symptoms are obscuration of vision and rainbow colored ring around a light. The anterior chamber may be shallower than normal and the pupil is sluggish with a tendency to dilatation.

These attacks last a few hours then seem to disappear to be followed at intervals by others of the same character. Between the attacks the eye seems normal except for an apparent presbyopia that becomes manifest.

The changes in the fundus at this time depend somewhat upon

the length of time the process has been going on and varies from slight congestion of the retinal veins with, perhaps, a pulsating vein or artery, to marked cupping of the disc.

The attack proper is ushered in with pain radiating from the eye along the first and second branches of the trigeminus, sometimes accompanied by vomiting. Vision is seriously impaired and the field of vision is narrowed, especially on the nasal side.

The appearance is that of severe inflammation of the eye. The lids are swollen, the conjunctiva congested and may be chemosed. The cornea has a smoky look and is insensitive to the touch. The anterior chamber is shallow, the pupil dilated and the iris discolored. The eye is manifestly hard to the touch. After a shorter or longer time the symptoms subside. A period of comparative or actual comfort supervenes to be followed sooner or later by another attack of pain etc. During these intervals the fundus may often be seen with the ophthalmoscope and the condition of the fundus noted.

There is not always a cupped disc after the first attack but after several such attacks the nerve head gives way to the intra-ocular pressure and the depression is manifest.

The disease usually affects both eyes, but one is attacked in advance of the other. It is seen more often in women than men and is a disease of later life. Usually appearing after the fortieth year and often in people of a rheumatic or gouty tendency.

#### DIAGNOSIS.

The disease may be confounded with erysipelas, neuralgia, biliousness, iritis, keratitis or conjunctivitis.

From the three first named diseases one can easily distinguish it if he takes into consideration the fact that the eye is the seat of the disease.

From iritis it is distinguished by the dilated pupil, the shallow anterior chamber and the absence of posterior synechia.

From keratitis by the absence of constitutional causes, the position and nature of the opacity and the dilated pupil.

From conjunctivitis it is distinguished by the opacity of the cornea, the dilated pupil, the shallow anterior chamber and the implication of the deeper blood vessels.

And from all of these diseases it is distinguished by the increased tension and insensitive cornea.

#### TREATMENT.

A large majority of the profession today, consider iridectomy the best treatment for acute congestive glaucoma, and with this I fully agree, but the fact that a number of experienced and capable

operators and observers advocate other methods is evidence of the fact that some-thing better is needed for the relief of this condition and leads us to a consideration of some of the other means adopted for its relief.

Holt of Christiania, produces a subconjunctival prolapse of the iris, in an effort to simulate a cystoid scar. He avoids infection by placing the conjunctival incision ten (10) millimeters from the limbus. His results represent about the same percentage of cures as Grosz, of Budapest, gives for iridectomy in the same class of cases.

Arnold Knapp, of New York, performs a posterior sclerotomy in those cases of acute glaucoma characterized by very shallow anterior chamber and much tension. This is followed by the ordinary iridectomy.

Anterior sclerotomy is seldom performed in acute cases being limited to those cases where iridectomy can not be done such as threatened hemorrhage etc.

Some patients present themselves for treatment who are unwilling to undergo any operation, or upon whom for other reasons it is unwise to operate at the moment seen and for these cases we are called upon to do our best to relieve the pain and restore, for the time, the eye to its best condition.

Bearing in mind the fact that these patients are frequently rheumatic, it is usually wise to put them upon the salicylates in full doses, for a time; first opening the bowels thoroughly with a saline or a calomel purge.

A 1% solution of eserine, preferably in olive oil, or a similar strength of pilocarpine or arecoline in aqueous solution is dropped into the eyes to contract the pupil, and a little dionin added to quiet pain.

If the response is not satisfactory massage may enable the excretory apparatus to perform its work better and thus absorb the remedies.

Sometimes a blister to the temple or the abstraction of blood by the artificial leech assists in relieving the congestion of the eye long enough for the medicines to assert their specific action.

In those cases where an iridectomy has been done resulting in improvement, but with some complaint of uneasiness, and vision does not promptly rise as it should I have found a continuance of the anti-rheumatic treatment desirable as it was in the case of Mrs. B. age 57 of rheumatic habit seen first May 10, 1905.

Her pain had begun in left eye Dec. 24-1904 but she had smoky vision with rainbow around a light for 2 or 3 years pre-



ceding this. Since the 24th of Dec. has suffered more or less pain and now has a dilated left pupil with T.+1. Eye injected and all the symptoms of acute glaucoma. V. R. E. equals twenty-thirtieths. V L. E. equals pl. over a small area toward temporal side but could not distinguish form with this eye. An iridectomy was done on each eye beginning with the left and the right operated upon after two weeks.

She was put upon the salicylates and eserine with the result that on March 26, 1906 her vision was twenty-twentieths for the right eye and twenty-fortieths for the left. There was marked cupping of the disc and narrowing of the field but the eyes are useful and I consider the result very satisfactory.



**Formic Acid as a Tonic After Diphtheria.**—In doses of from five to twenty minims of a twenty-five per cent. solution, formic acid is recommended for its tonic and stimulating effects in convalescence from diphtheria, by C. B. Kerr and D. H. Croom. It is given in the doses stated every four hours.—

Berliner klinische Wochenschrift, June 22, 1908



**Application for the Prevention of Bedsores.**—The following applied as a varnish twice daily to the parts menaced, will act as a preventive of bedsores:

Guttapercha..	3i;
Chloroform.....	3i;
Balsam of Peru.....	gtt.XV

M.

N. Y. Medical Journal.



**Application for Pruritus Ani et Vulvæ.**—A paste of the following composition maybe applied to the parts affected:

R Salicylic acid.....	gr. xxx;
Phenol.....	gr. xv;
Tartaric acid.....	gr. xlv;
Glycerite of starch.....	3iii;

M.

To be followed by the free use of a dusting powder:

R Powdered talc.....	3vii;
Zinc oxide.....	3i.

M.

N. Y. Medi. Journal.

# THE JOURNAL

## OF THE

# Kansas Medical Society.

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JAMES W. MAY, - - - - EDITOR.

J. E. SAWTELL, { ASSOCIATE EDITORS } CHAS. S. HUFFMAN.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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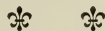
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## EDITORIAL

The columns of this Journal are open at all times for the expression of opinion on subjects of interest to the medical profession and it is expressly desired that clinical or news notes be sent to the editor for publication where proper credit will be given.



Did you ever scan the news notes of the Journal A. M. A. and find anything there from Kansas? If you did it was a great exception and does not occur once in many moons. This condition of things is our own fault as the Journal is willing at all times to print notes from this State as well as any other. Will not some one volunteer to furnish the A. M. A. Journal with items showing that Kansas, the greatest state in the Union, is also in the front rank in medicine and surgery—"Stand up for Kansas."



At the next meeting of our society let's have a committee on preventative medicine formed, whose duty it will be to help eradicate gonorrhoeal, ophthalmia, trachoma, small pox, scarlet fever, tetanus from insane 4th of July celebrations and many other diseases which can absolutely be prevented. This committee should work first by a campaign of education directed to physicians

and also the laity; second by a campaign of legislation, and it seems that it would accomplish much and be of lasting benefit.



The benefits from good medical legislation which has been enacted during the past ten years can hardly be estimated. When one stops to think of the benefits derived from the pure food and drug laws which have but recently taken effect we wonder why the profession at least was not aroused from its lethargy long enough to realize what might be accomplished. This is only a small part of what has been accomplished, for one has but to glance over the records of the legislatures to know what has been done in helping to put to rout charlatans (by having a rigid examination to pass), the promotion of vital statistics, and numerous other measures of protection. It behooves us as professional men to help elect legislators who are in sympathy with the progress along these lines. A start has only been made and we must be eternally up and doing to accomplish results.



Your editor during his recent sojourn in Chicago at the A. M. A. meeting, by a mistake wandered into the meeting of the association of medical editors of America. It is composed mostly of editors of the independent medical journals. There were many brilliant medical writers present and many valuable papers were read and discussed. The whole business part of the meeting seemed to be an attack on the A. M. A. Journal for its stand in regard to accepting no advertisements of preparations not passed by the Council of Pharmacy. When one stops to think of the number of medical journals which would have to quit business if they refused the "ads" of semi-patent medicines it is no wonder that a mighty protest was registered. If a medical Journal cannot exist without accepting questionable advertising then let's sound the funeral dirge and let their expiring gasps give music to our ears.



At the Chicago Session of the American Medical Association the following resolution was adopted by the House of Delegates and the General Secretary was instructed to bring it to the attention of all state associations:

Resolved, That this Association heartily approves the action of the Board of Trustees in restricting advertisements of medical preparations to those approved by the Council on Pharmacy and Chemistry: and further

Resolved, That this House of Delegates requests all those state associations which now do or hereafter may publish or con-

trol medical journals to restrict their advertisements to such approved preparations, and that the General Secretary be requested to bring this resolution to the attention of all state associations.

The above communication has been sent to our secretary to submit to the State Society. In all probability the society will decide but one way, and that is to sustain the American Medical Association. The time is right at hand for us to question every person who is introducing some drug or compound as to whether it has been approved by the Council of Pharmacy of the A. M. A. This is our only safe guard for we have no other means of proving the manufacturers statements. The Council has been very lenient with the manufacturers and have turned down none of the preparations without abundant reason. We have been fooled long enough by these houses whose claims are not substantiated by fact and they must now "deliver the goods."



CRIMINAL ABORTION.—The time was, and not long since, when altogether too many of the reputable members of the profession looked with more or less indifference upon one of the most heinous crimes known to the civilized world, that of criminal abortion. Since a more thorough medical organization has been established throughout the country and a better knowledge of the principals for which organization stands has been disseminated, there seems to be an awakening of sentiment in opposition to this enormous offense against law and morality. It might appear to some that this criminal practice is on the increase on account of the more frequent notices of criminal prosecutions appearing in the daily papers but relatively speaking this is not true. As population increases and becomes more dense the greater is the demand for criminal acts of this kind and it is too often met by the mercenary and disreputable element of the profession who are either opposed to, or have no just place among the organized profession. That prosecutions of this class of practice are on the increase there is no doubt but that to medical organization is due the credit is evidenced by the fact that the most potent influence in this direction is always exerted by the members of our medical societies.

County societies should heartily join hands with the legal authorities in helping to stamp out this crime, for we owe it not only to society at large but to the reputation of the profession which is our duty to uphold.

J. E. S.



HOW IS THIS.—It is reported that a coroner in London impanelled a jury to determine whether the operation was justifiable which resulted in the death of a patient.

Sir Victor Hosley was summoned as a witness in the case. There is need of such a jury at times. There are, no doubt, human lives sacrificed almost daily from unnecessary, uncalled for, and bungling operations. Too many operations are done, operations that are too radical. There should be more conservatism.

This charge will not hold against the better class of good physicians and surgeons. By good is meant by those who are conscientious and skilled in the profession. It does apply to fakirs both outside and some who are recognized in profession, and especially the latter class bring a stigma on the whole profession. It creates a doubt in the mind of the laity when they know of operations being needlessly done, and sometimes ending fatally, whether any operation should be done, and often delay has been fatal because of such an experience of meddlesomeness on the part of the so called surgeon. For example, what a frightful appearance an injured eye may present and yet be saved. On the other hand, an eye should be removed at times when to all outward appearance there is but little showing of injury or disease. In the first case, the unscrupulous fakir has clear sailing. From the appearance of the eye to the patient and friends, consent is readily given to enucleate the eye which could be saved of, at least, an effort made to save it. For there is no danger in ten days or two weeks delay in such cases. But there is more money in an enucleation, to the scoundrel. There is a greater name and honor in operating. There is less labor, and altogether the unscrupulous man has greater financial interest in doing the least and getting the most for it. The mutilation of the patient does not affect him.

In the other case, when the physician or surgeon knows from the failing sight of the injured eye, and the slight scleral or circumcorneal zone of redness and the dread of light in the uninjured eye, the damage through sympathetic inflammation and loss of sight of the good eye, that the offending eye should be removed, the patient and friends hesitate until it is too late and the irreparable mischief is done; because some fakir has destroyed their confidence in an unnecessary, uncalled for operation on some friend or acquaintance.

What is the remedy? Publicity. The public is more or less aroused, as indicated by the London coroner's action. But the exposure should be made by the profession. Half of the

jury at least should be composed of reputable physicians, and after a careful deliberation justice could be meted out. Such a course would tend to check this indiscriminate operating. More lives would be saved and fewer people go through life maimed and mutilated.

J. E. M.



## CLINICAL NOTES

YELLOW OXIDE OF MERCURY is a good remedy for furunculosis of the external auditory canal. Especially is this true after the furuncle has been incised and to prevent their recurrence.



An old, narrow Graefe cataract knife is an ideal instrument for opening the drum membrane in suppurative otitis. Ethyl chlorid narcosis is best for this brief operation.

American Jour. Surgery.



Instead of suturing the skin after amputation of an extremity, it is sometimes better to bring the flaps together with broad strips of adhesive plaster, especially if the operation performed is for an arteriosclerotic condition.

American Jour. Surgery.



MEANINGLESS DIAGNOSES.—H. L. Wiel, San Francisco (Journal A. M. A., June 6), thinks the time has come for the medical profession to stop the use of certain ill-used but time-worn diagnoses which mean nothing definite and are used merely to hide ignorance and satisfy the patient. Perhaps the most freely used of these is bilousness, which is no diagnosis at all, and he also mentions as falling into the same category typhoid pneumonia and typhoid malaria, ptomain poisoning, a frequently misused appellation, and gastric fever. There are many others, and he asks, "Should not all conscientious physicians discard the use of these terms, and if there are none better to be found in the present terminology, why use terminology at all?" Rather than call things by false or meaningless names, let us call them by no names at all.



## OPHTHALMIC NOTES.

By DR. J. E. MINNEY.

An almost universal collyrium in all forms of conjunctival troubles and in ulceration of the cornea an eye wash that will

meet more indications than any one other agent is the following:

R Acidi carbolici 95%..... gtt. v-x;  
 Aquae distillata..... ʒi.

Sig: Apply from five to ten drops to the everted lids, hold for a few moments, then let the lids return,—do not wash off the excess.



In case of ulceration of the cornea, the pupil should be kept dilated with atropia as per prescription:

Rx Atropiae sulphatis..... grs. ii-iv;  
 Aque Dist..... ʒi.

Sig: Put two or three drops on the cornea once or twice a day.



2. Another eye wash but not so soothing in irritable conditions of the external eye is:

R Glyco-Thymolini (Kress)..... ʒi.

Sig: Apply from five to ten drops to the mucous surface of the everted lids, hold for a few moments and then return the lid to their normal position. If much smarting, put a small quantity of cocaine ointment in the eye—one grain of cocaine to one ounce of vaseline.

These applications may be applied as indicated, twice a day, daily or every second day.



The lead style is being used again, instead of the silver tube in keeping the nasal duct open. The duct is dilated a time or two and the soft lead style No. viii is introduced and let remain for an indefinite time, unless there are intoward symptoms. It is soft and moulds itself readily to the canal and has no opening like the silver tube to serve as a breeding place for bugs.



## NEWS NOTES

Dr. A. H. Cordier and family of Kansas City, Mo., has left for Canada and Alaska on a hunting trip.



Dr. W. K. Trimble of the University of Kansas has returned from the east where he took post graduate work at Harvard University.



Five members of the graduating class of the University of Kansas have accepted positions in the City General Hospital of Kansas City, Missouri.

DR. J. F. BINNIE of the University of Kansas will spend the summer travelling in Europe and visiting the various clinics. He will return in October.



Dr. M. C. Porter, formerly of Clay Center, Kansas, is now in partnership with Dr. John H. Outland for the practice of surgery exclusively. Located at Topeka.



**Correction.**—The article in the July issue on Iritis by mistake was credited to Dr. A. C. Graves, Pittsburg, Kansas. It should have been Dr. W. H. Graves of the same place.



**The Medical Association of the Southwest**, which embraces the state of Kansas, Arkansas, Oklahoma, Texas, and Missouri, will hold its annual meeting in Kansas City, Mo., on October 20th and 21st. Dr. John Punton is chairman of the committee of arrangements.



Rice County Medical Society, program for August 20 at Lyons, Kansas.

The Physician's Wife.....	Mrs. E. C. Fisher
Antrum Trouble.....	Dr. Gregory
Legal Medicine.....	Hon. O. A. Hopkins



There was a good attendance at the July meeting of the Shawnee County Medical Society.

Dr. W. C. McDonough reported a case of appendicitis in a woman who refused operation. After weeks of suffering it terminated favorably by rupture into the bowel and discharge of pus by rectum. Dr. Harriet E. Adams reported three cases of trichophytosis capitis.

Dr. W. W. Yates presented a good paper on nephritis which was freely discussed.

Dr. T. P. Scott was elected a member.

J. B. TOWER, Secretary.



**THE INTERNATIONAL CONGRESS on TUBERCULOSIS** will hold its meeting at Washington, D. C., Sept. 21st. to Oct. 12th. 1908. This will be an event of great importance, and since such a Congress cannot occur again in the United States for 25 or 30 years to come, the opportunity which it gives to us of the passing generation is literally unique. President Roosevelt has



accepted the presidency of the Congress and Dr. Jno. S. Fulton, of Washington, D. C. is Secretary-General.



#### KANSAS MEDICAL COLLEGE, TOPEKA, NOTES,

The Jonathan Thomas Memorial Gymnasium at Washburn will cost \$45,000. It is in course of construction and will be finished by the holidays.



The rebuilding and remodeling of Rice Hall at Washburn at a cost of \$30,000 will add to the appearance of the building and make it much more up to-date than the old building, which was destroyed by fire last winter.



It is the plan of the administration of Washburn College to set apart an endowment of \$100,000 for the Medical Department and to expend \$50,000 in improvement and equipment in the near future.



A special course of instruction will be given at the Kansas Medical College and the various hospitals in the city, beginning August 31 and continuing one week. The Alumni of the College will attend and a general invitation is extended to physicians.

The following program has been prepared.

#### PROGRAM.

##### MONDAY AUGUST 31.

- 9-12 Surgical Clinic at Christs Hospital by Drs. McClintock, Bowen and Kiene.
- 2-4 Practical Clinical Haematology at Pathological Laboratory by Dr. Hammel.
- 4-5 The Eye in General Diseases—Lecture by Dr. J. E. Minney
- 8 Address by Pres't. Sanders, followed by a Reception.

##### TUESDAY SEPT. 1.

- 9-12 Surgical Clinic at Santa Fe Hospital by Drs. Kaster and Freeman.
- 2-4 Practical Clinical Haematology at Pathological Laboratory by Dr. Hammel.
- 4-5 Lecture on Pediatrics by Dr. Peers.
- 8 Lecture by Dr. Dillon, Larned, Kansas.

##### WEDNESDAY SEPT. 2.

- 9-12 Surgical Clinic at Stormont Hospital by Drs. Munn and McGuire
- 2-4 Practical Clinical Bacteriology at Bacteriological Laboratory by Dr. Greenfield.

4-5 Lecture by Dr. O. P. Davis.

8 Lecture by Dr. Frankenburger, Kansas City.

THURSDAY, SEPT. 3.

9-12 Surgical Clinic at Bethesda Hospital by Drs. Outland and Porter.

2-4 Practical Clinical Bacteriology at Bacteriological Laboratory by Dr. Greenfield.

4-5 Dieto-therapy of Diabetes by Dr. Menninger.

8 Lecture by Dr. Walker of Wichita, Kansas.

FRIDAY SEPT. 4.

9-10 Adenoids—Lecture and Demonstration by Dr. Alkire.

10-11 Lecture on Diabetes by Dr. S. G. Stewart.

11-12 Atypical Pneumonia—Lecture by Dr. McGuire.

2-5 Lecture and Clinic at State Hospital by Dr. Biddle.

8 Demonstration and Lecture on XRay by Dr. Johnson.

SATURDAY SEPT. 5.

9-10 Amnesic States—Lecture by Dr. Lindsay.

10-11 Lecture by Dr. W. E. McVey on Treatment of Cardiac Disorders.

11-12 Pott's Disease—Clinical Lecture by Dr. Storrs.

2-3 Lecture by Dr. Mitchell.

3-4 Internal Secretions by Dr. Warriner.

8 Lecture and Demonstration by Dr. Turk of Chicago.

Banquet.



BOOK REVIEW.

"A Mind That Found Itself."

An autobiography by Clifford Whittingham Beers. Cloth; Octavo. Pp. 363. New York, 1908. Longmans, Green & Co.

This is an unusual sort of book in that it is the very carefully and sanely worked out thesis of a man who has been insane and recovered. His recovery and the truth of his statements are vouched for by some of the best alienists of the country, and in particular by William James of Harvard.

Mr. Beers graduated from the high school at New Haven, Conn., in June, 1894. A brother of his died about that time of what was thought to be epilepsy and the fear of this disease seems from then on to have become a fixed dread in the young man's mind until it had taken entire possession of his life.

Nevertheless he entered the Sheffield Scientific School of Yale University and managed to go through the whole four years' course, although with some difficulty because of his apparent inability to master his nervousness. He graduated from Yale June 30, 1897, and immediately went into office work, first as a clerk in the office of the collector of taxes in the city of New Haven, and then a year later with a business firm in New York City. In March, 1900, he was attacked by la grippe and as a result nervous troubles ensued which compelled him to give up work and return home. He of course believed that he was becoming epileptic and wished rather to end his life than to undergo the horrors of that disease.

Consequently on the 23d of June, 1900, he endeavored to commit suicide by dropping out of the fourth story window from the room where he had been lying ill. He dropped however on to turf instead of the pavement and as a result only crushed both ankles in place of killing himself; and what is stranger still the delusion or the dread of epilepsy disappeared, with the shock and in its place came on a psychosis in the form of an attack of severe depression or melancholia.

He was removed to a general hospital and went through the usual sufferings not only those incident to broken ankles but also those of a melancholic who believed that all persons around him were in league against him, that everybody was trying to poison him or send him to jail, that he had committed an unpardonable crime and disgraced his family,—and all that sort of thing. He suffered from hallucinations, particularly those of hearing and sight. During this treatment he was kept in bed with his legs in casts. As soon as he could be moved, he was put into a private hospital for the insane. This asylum was one conducted for profit by private individuals and conducted badly. He was confined with a "muff" and treated as if he could not think and could not appreciate what was being done and he shows how these things instead of helping him to master himself and keep more quiet made him more violent and desirous of putting an end to himself and destroying things about him. During this time he could not talk and was practically cataleptic. He pictures vividly the treatment given him by the physicians who seemed to treat him more as a machine or an animal than as a human being. His final recovery to reason was probably insured at this juncture by securing as an attendant a man more humane than the ordinary brutal attendant, who although ignorant of psychology believed in non-restraint secured his confidence and tried to do his best for him. This attendant finally secured his release from this private sanitarium (God save the mark!). But after it had been found impossible to care for him adequately at home he was sent to another institution, private also, but endowed and not run for profit. Things went well here until he came under the care of an assistant physician with no conception apparently of the correct treatment of the insane. He was still trying to commit suicide and had made every preparation to do so when by a clever ruse he proved to himself that the man who came to see him and claimed to be his brother was really his brother. As soon as his mind was clear this point, he rebounded from the depressed condition to the elated and expansive one and proceeded to take a very active interest in life, and especially in the lives of his fellow-patients. This was on the 30th of August, 1902. His interest in his fellow-patients led him to interfere so frequently with the routine treatment established by physicians and the attendants that he at once got into quarrels with the latter, and they no longer treated him as convalescent but proceeded to choke him and otherwise reduce him to submission. And finally when simple beatings did not compel him to desist from criticising them, they put him in the "bull pen" and the strait-jacket. Here he was kept for nearly three months, without sufficient clothing, without adequate food, and without means of keeping himself clean—all simply because he believed that he and his fellow-patients should be treated as men and not as brutes or as machines.

For instance, on the 18th of October, 1902, he had three fights with his attendants, and finally choked into insensibility. From that time he was kept in close confinement without his clothing and without humane treatment until the last of December. Finally, he managed to get word to his brother of his treatment and was removed from this institution and placed in a state hospital for the insane where he was better treated although he soon came into collision with one of his attendants and was put into a violent ward. He describes the methods of treatment employed upon him and upon kindred patients. He describes in detail the outrages (which sometimes amounted to murder) that he saw committed and has equipped his narrative with facts and figures in such a way as to make it very convincing. While in the violent ward of the state hospital, where he was placed January 1903 he finally managed to communicate with his brother and the Governor of the state, and at last was moved back into one of the quiet wards March 3, 1903.

During these months of elation (since his recovery from the depression ending Aug. 30, 1902) the idea of securing reforms in the treatment of the insane had been his one absorbing passion and he had made exhaustive studies into the treatment of his fellow-patients, the character of the attendants and physicians and had been eager to be put into the violent wards just to see how they were conducted—making all sorts of daily memoranda in preparation for his work. As his expansive condition spent itself, he was able to keep this purpose somewhat in subjection and when he was finally dismissed from the state hospital in May 1903 and allowed to go back to business, he worked for one year before he found himself ready to give up his business to devote himself to the prosecution of his crusade. The first result of this propaganda was that he was put back into an asylum but he demonstrated so quickly that he was perfectly self-controlled, that he was allowed to go out after a month's confinement. He has devoted the greater part of his leisure time since then to the arrangement of the material which constitutes this book. During this period he submitted his manuscript to all sorts and conditions of critics—from Joseph H. Choate to neurologists, psychologists, alienists and physicians, having each one criticize and blue pencil it until the statements made should be sound and authentic. During all this time, he was making a good income from his business and proving himself an efficient member of society.

His book is one great plea for non-restraint and I can do no better<sup>r</sup> than quote some of his sentences. For instance, the following from Page 298: "It is evident therefore, that insanity, if it is ever to be conquered, must be attacked along lines not commonly followed today. As to the method of attack to adopt there can be no argument, for the masters of medical education in every country in Europe have proved the practicability and value of the plan in question. What is needed in order to reach the root of the problem of insanity is the establishment of so-called Psychopathic Psychiatric Hospitals in connection with our medical schools—hospitals where in nervous and mental diseases may be treated in the most scientific manner, not only for the benefit of the patients but also for the benefit of the physicians and students. What a leap forward in humanitarian endeavor it would be if each university, so situated and organized as to warrant it, should have under its everlasting protection a modern psychopathic hospital! And what could be more appropriate than the restoration of lost reasons under the hospitable protection of the very institutions wherein reason itself is trained to do its right work? Further, psychopathic hospitals will enable scientists to study insanity; and such institutions by setting a high standard, will soon raise the standard of treatment throughout the country. The necessity for such modern hospitals may be appreciated when an accredited authority in this country in matter pertaining to medical education (Dr. William H. Welch of Johns Hopkins University) can say, as he did to the writer of this book: 'The most urgent need in medical education in America, today, is the need of psychiatric clinics (psychopathic hospitals) where medical students and physicians as well may benefit by instruction in psychiatry, and where scientific research into the cause and cure of insanity may be carried on unceasingly.' When the fact is considered that each university in Germany, France, Italy, Switzerland, Austria, Russia, Norway, Sweden, Denmark, Holland, Belgium, Brazil, Argentine Republic and Japan, at the present time, has a psychiatric clinic under its own control, and that no physician in most of these countries may practice medicine until he has passed a satisfactory examination in psychiatry the disgraceful state of affairs existing in this, the richest nation in the world, may be the more readily appreciated. In the light of such embarrassing facts, it is indeed high time that the United States of America should prove itself the vauntedly progressive nation it is supposed to be by taking hold of the neglected problem of insanity, and through its several state legislatures bringing into existence psychopathic hospitals of the type described in the interesting U. S. Consular Report on the Munich Clinic (Kraepelin's). Thus far, Michigan is the only state in the union to erect a modern psychopathic hospital. New York however has taken steps toward the erection of one, a well meant though totally inadequate appropriation having been voted for the purpose. As each community owes



it to itself to make provision for the prompt treatment of causes of incipient insanity, and thus spare the individual the ordeal of commitment as an incompetent, it is fortunate that relief is at hand for such cities as cannot maintain a modern psychopathic hospital. Here the so-called general hospitals may be put to full use. Separate buildings, or pavilions, may be erected and maintained at comparatively light cost, as has already been proved by the success of the psychopathic hospital at Ann Arbor, Michigan. That is to say, for considerably less than \$100,000.00 an efficient department of mental and nervous diseases may be organized and brought under the control of any well managed general hospital. Though there is but one general hospital in the country where this problem has been worked out, the results of what five years ago was an experiment have justified the rather startling venture made by the pioneer in this important work. Dr. J. Montgomery Mosher, Specialist in Nervous and Mental Diseases at the Albany Hospital, Albany, New York, is the man who has had the courage and good sense to go ahead and prove that a general hospital should and can receive and treat mental diseases as successfully as the diseases which are now treated without question in such institutions. \* \* \* He says: 'From February 18, 1902, the day of the first admission to February 28, 1907, 1,030 patients have entered the building. Of these 596 have returned to their homes recovered and improved; 316 have remained stationary; and 86 have died. 245 have been transferred to institutions for the insane; of these 126 were sent to Pavilion F for detention during the legal proceedings, and 118 were committed after a brief period of observation. It thus appears that 905 patients have been under treatment without legal process, 118 of whom it became necessary to commit later to institutions for the insane. If this special provision for the treatment of the mentally deranged had not been made in the Albany Hospital, then these 908 patients would either have had to be improperly treated at home, or would have been committed after a probably harmful development of the disease.'

His proposal is then in short that our medical schools be equipped with psychopathic hospitals and the medical education include some real instruction in psychiatry. Every medical man will, I believe, heartily endorse this proposal.

His second proposition is that every large general hospital should include a pavilion for treating the acutely insane. This avoids the odium of commitment to a state institution, and insures the attention and attendance of specialists for the various departments of general medicine and surgery. It would make possible the treatment of the insane in nearly every city and therefore nearer the friends of the patients.

Practically all alienists now agree that the state institutions for the care of the insane should be of two characters: (1) the custodial, and (2) the psychopathic or reception hospitals. Now however both functions are being placed upon single institutions except in Michigan. The objection to the Michigan system comes strangely enough from the heads of the state hospitals, who say that the reception hospital at Ann Arbor takes away from them all the interesting work, and makes the other institutions purely custodial. This objection to the division of the work should of course be listened to, but should be evaluated only as it affects the welfare of the patients. The question is not, how do our present institutions look upon the proposal? but rather, would it benefit the people of the state to separate the custodial from the therapeutic institutions?

The question will soon come up in Kansas and the legislature will be called on to decide where to locate the reception hospitals now demanded by the increase in the insane population. One suggestion is to establish such psychopathic wards at Topeka and Osawatomie, and thus make these institutions combine the functions of the two types of institutions, and another is to give the University of Kansas at Rosedale a psychopathic hospital for training the physicians of the state in psychiatry.

In general then Mr. Beers' book touches upon a very vital problem and treats it in a most fascinating manner. It is worth the perusal of every good citizen, whether physician or layman.

DR. G. H. HOXIE.

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## THE VACCINES IN CHRONIC OTITIS MEDIA.

DR. WILLIAM K. TRIMBLE, Rosedale, Kansas.

Read Before the Kansas Medical Society, May 8, 1908.

All physicians are now more or less familiar, at least, in a general way, with the principles applied in the treatment of various injections by the use of killed cultures of organisms, or, so-called vaccines. Some doubt exists in the minds of medical men generally, as to the efficacy of this treatment. That the vaccines are efficacious in the treatment of certain suppurative diseases is now very well established. There is an important question to the practitioner, what types of infection respond to this treatment and what particular cases should be chosen to receive this treatment?

As to the scientific principles underlying vaccine therapy there can be little doubt as to their correctness, indeed, the whole can be demonstrated experimentally and is but a revival of the old method, with modifications, of inducing immunity by artificial means.

It is a common observation that persons by constant use can become accustomed to large doses of poisonous drugs. Persons so accustomed are said to have developed a tolerance for the drug, and, while drug tolerance is not considered an immunity in the ordinary sense, yet regardless of what it may be, it illustrates the fact that such a persons body tissues are able to take care of over doses of a drug without fatal results. More explicatory the principles are shown in the experiments of inducing immunity by the inoculation of both dead and living cultures of organisms. Pfeiffer rendered animals immune to cholera vibrios by the repeated injection of killed cultures of this organism. Animals so immun-

ized when given inoculations of living cultures recovered completely. Whereas, animals not so immunized when given this same dose invariably die of an intense septicemia. Likewise, animals may be so immunized against other virulent organisms.

When living virulent anthrax is introduced into the peritoneal cavity of an immunized animal, in a short while the organisms disappear, the animal recovering. If immunized animals are given subcutaneous injections of living virulent anthrax, supuration occurs at the point of inoculation,—the animal recovering. If this purulent fluid is examined it will be seen that phagocytosis has occurred to an enormous degree. On the other hand, non-immunized animals when given this same subcutaneous injection invariably die of a septicemia. This experiment shows that during the course of immunization against anthrax, there is elaborated some body which enables the body cells to overcome the infection, and, since phagocytosis is so conspicuous in the purulent fluid, we may suppose that this body acts in some way as to favor phagocytosis. In this phagocytic process is found in part, at least, the process of immunity.

Metchnikoff adhered to the belief that all phagocytic processes were purely independent properties of the leucocytes. Ehrlich holds the theory that the act of phagocytosis is a secondary process which depends primarily upon some property of the serum. It is very well established that the latter view is the correct one, as the following experiments go to show: If we mix a loop full of a suitable suspension of an organism with a loop full of whole blood and incubate as a hanging drop in a sealed excavated slide for 15 minutes at 37°C., and then examine the mixture by making suitable slides and stain, we can see that phagocytosis has taken place to a considerable degree. This does not show whether phagocytosis is due to some property of the serum or purely an act of the leucocyte. If we take serum free cells and place with the organisms under like conditions, as above, we find that phagocytosis has not taken place. If, on the other hand, we place the organisms with the serum and then with the leucocytes, phagocytosis will occur in the same degree as when whole blood is used. By the same method it can be shown that the leucocytes of an animal rendered immune to anthrax will engulf more anthrax organisms than the leucocytes of non-immune animals. Anthrax organisms subjected to the action of the serum of immune animals then to leucocytes will show greater phagocytosis than when organisms have been subjected to the action of serum from non-immune animals. These experiments show fairly well the principle upon

which vaccine therapy is based and proves that the serum has some influence upon the organisms as to render them capable of being taken up by the leucocytes.

Wright, in a communication to Douglas, to designate this property of a serum, made use of the word opsonon, and such properties of sera are now known as opsonons.

It follows then, that the object to be sought in the treatment of infections by the inoculation of dead cultures is to raise the opsonic powers of the serum. While these properties of a serum can not be raised to such a degree as to produce a striking immunity as is obtained by the use of diphtheria anti-toxin, yet they can be raised to such a degree, and if persistently maintained for a sufficient length of time, will greatly aid natural processes of overcoming infection.

At present it is difficult to say just what type of infections may best be treated by the vaccine method. The limits of its application being, as yet, not at all well defined. There is some evidence to suppose that certain types of infection do not respond to this treatment.

Streptococcus infections from personal experience, and from others, we can safely say that this method is not sufficiently satisfactory to justify it being recommended, or at least, where it is being used to continue the treatment where patients do not show marked improvement early, for it is obvious that in some such cases delayed improvement may result in wide spread infection and serious results follow. On the other hand, in cases due to the staphylococcus, the gonococcus and the tubercle bacillus have, by this treatment, shown marked improvement with many cures. However, in judging results of this treatment one is confronted with those cases, sometimes with severe infection, which recover promptly under usual treatment or sometimes without treatment. Yet, regardless of such instances, in a number of cases which have persistently resisted the usual therapeutic measures, I have seen them improve so promptly under the vaccines that credit must be given the method.

Out of a number of cases of chronic otitis media treated at the Bell Memorial Hospital, a number have promptly recovered. Others so treated have persistently refused to get well though improvement was marked. Just why these failures it is difficult to say. With reference to the lesion there are three things upon which success depends. The character of the infection, the depth and amount of tissue involved and the efficiency of the drainage. This seems to be placing numerous restrictions, but success by



any method depends upon these very conditions, save operative. That cases are favored by mild infection, little tissue involvement and good drainage is evidenced by spontaneous recovery of a large number of cases. Other cases not so favored may discharge for months or the patient have recurrence of pain, fever, etc. These cases due to the staphylococcus usually respond to the vaccines,—the discharge disappearing after three or four inoculations, without recurrence. It is, however, only sensible in virulent staphylococcic infections to do a radical operation early. Such cases, of course, are characterized by profound disturbances and are easily excluded from all but operative measures. However, these cases even, when the organism is obtainable should be inoculated, especially if there is delay for any reason in operating. I have seen one case of subacute otitis media due to the streptococcus where operation was at first refused but inoculations given, followed by a fall in the leucocyte count from 16,000 to 12,000 per cmm. and quite an improvement in the general condition of the patient.

The following is a report of four consecutive cases of otitis media treated with the vaccines:

Miss Q., age 9 years. Two years previous had scarlet fever followed by otitis media. Ear has discharged continuously for two years. Accompanying acute coryzas patient would have some pain in the ear followed by increased discharge. Presented for treatment Aug. 11, 1907. General appearance of the patient not up to the standard. Temp. 99.4 F. Culture from ear showed staphylococcus aureus from which a vaccine was made.

Aug. 13, 1908.—Patient was given an inoculation of 250M organisms. Eight hours later patient complained of stiffness of the joints with much tenderness at the point of injection,—both symptoms disappearing in 24 hours.

Aug. 16.—Patient received 100M organisms,—no stiffness followed.

Aug. 20.—Slight discharge, patient given 100M organisms.

Aug. 25.—No discharge, patient given 100M organisms.

Sept. 2.—No discharge, patient given 100M organisms.

Sept. 15.—No discharge, patient given 100M organisms. Patient was discharged. Appetite unusually good. Gain in weight, 6 lbs.

Miss P., age 22 years. Chronic otitis media for 9 years, characterized by recurrent attacks, 3 or 4 a year, following "colds in the head." Discharge not noticable between attacks. Was first seen during an attack. Palliative measures given. On the

following day discharge was present. Culture showed staphylococcus aureus. Innoculations were given every 4 to 5 days of 200M. organisms. Four treatments were given when patient returned to work with slight discharge from the ear. Failed to report for continued treatment. After 6 months she informed me that she has had no recurrent attacks but that a slight discharge continues. At this time she expressed a wish to have the treatments continued but has not reported.

Mrs. B. One child two months old. Mother entered hospital with a copious discharge from the ear,—pain, dizziness, fever, etc. Culture showed *B. pyocyaneus*. Innoculations were continued for some time without apparent results. She eventually recovered sufficiently to leave the hospital and resume her household duties.

Mrs. C. Chronic otitis media for 21 years following scarlet fever. Case characterized by a constant discharge. For years treated sporadically. Patient in unusually good health. Culture showed *B. pyocyaneus* and staphylococcus albus from which a mixed vaccine was made. Three inoculations were given at 3 and 4 day intervals when the pyocyaneus disappeared. A fresh vaccine of the staphylococcus was made and continued at longer intervals for 6 weeks when patient was discharged. After 4 months no evidence of the trouble has reappeared.

Mr. G., 23 years. Two months previously had a severe attack of otitis media with involvement of the mastoid. Rupture spontaneous. Only partial relief from pain followed rupture. At time patient reported for treatment, Temp. 101°F.,—profuse discharge from the ear. Swelling and tenderness posteriorly and above the ear,—much dizziness. Leucocyte count 16,000. Culture showed streptococci from which a vaccine was made. Patient received 20M. organisms every 3 or 4 days for several weeks with no apparent improvement. When the case returned for the second treatment the leukocyte count was 12,000, above which it never arose. This case was operated upon later and considerable necrosed bone removed. Patient recovered. It was interesting to note in this case the few organisms which could be found in the discharge after three weeks treatment, whereas, at first they were numerous. This patient refused operation at first.

All cases of chronic otitis media in which symptoms are scarcely such as to justify operating should be given the vaccine treatment. Failure will follow in many cases, but so also does other treatment fail; but on the whole this treatment has back of it good scientific principles, and without doubt, when judiciously

used will offer the greatest percent of recoveries in a given number of cases. Indeed, the usual treatment need not be discontinued, and every case should be in the hands of the specialist. The good that can be done should not be judged by the results of a single method of treatment to the exclusion of all others, but judged by the greatest number of recoveries as the result of any single method of treatment or any combination. If a higher opsonic index in a patient's serum is an aid to irrigation, dry packs, etc., then the vaccines should be used. Experience with the vaccines certainly justify their use.



## CONVULSIONS, RESULT OF COMPLETE VAGINAL ATRESIA.

By G. B. McCLELLAN, M. D., Weir, Kansas.

Read Before the Kansas Medical Society, May 8, 1908.

During the summer of 1906, I occasionally had some inquiry from Mrs. A., in regard to what the family called "spells" of their daughter, an apparently strong, healthy, and intelligent mulatto girl, between seventeen and eighteen years of age. She had suffered no sickness since infancy, when she had a congenital obstruction of the rectum. That subsided, however, on dilation of rectum by an old negro woman, by means of a lead pencil, used similarly to a wooden dilator. Since then, and until her 14th year, she did not have any severe constipation, rapidly assumed womanly development, appearing rather fleshy, but altogether a well-proportioned girl for her age. She had all the symptoms of regular menstruation, except the vaginal discharge, and at times, when the usual symptoms came on, would have a very profuse nasal hemorrhage for a few minutes.

Her mother stated that from a teacupful to a quart of blood came in spurts from her nose, after which her headaches were relieved, and she was all right until the next month. When the nasal hemorrhages occurred, she suffered less than when she cramped and nose did not bleed. They did not use cold applications, as bleeding of nose always relieved her. There was no tendency during these disorders to bite the tongue, the saliva was not marked, there was no paralysis, left ovary most sensitive, and soreness not severe after such paroxysms. Her symptoms seemed to be in proportion to her menstrual difficulties, and constipation did not seem to affect nasal hemorrhages.

When this girl came to see me, she weighed 180 pounds, her height being 5 feet and 6 inches. Her parents are industrious, honest, light mulattoes, careful not to contract debts beyond their ability to pay, and for that reason did not take the girl to a physician, and thinking because of her apparent health, that when older these derangements would subside. They treated her during these menstrual disorders with domestic remedies, and drug-store-counter prescriptions, all of which failed to relieve her.

Different physicians being consulted from time to time, gave laxatives, female tonics, etc., but did not examine vagina. Her parents thought these remedies some times benefitted her, as in from two to five days she would gradually clear up, and appear as usual until her next time for menses, when she would pass through the same experience of apparent suppressed or vicarious menstruation. The continued regularity and increased severity of these disorders, finally alarmed both parents and girl, when I was consulted for treatment, I told the parents that I would give treatment usual in such conditions, and if this did not relieve her, to bring the girl to my office for examination. They agreed that if the medicine did not relieve her for that month, to bring her to the office, should obstructed flow still exist. I then prescribed mild chloride of hydrargyrum, in medium doses, p. r. n., with salines, quinine and salol, viburnum compound; ergot and gossipium after dilation, with chloral and bromide of potassium and passiflora for nervousness; chloroform to inhale until opiates of morphia and codeia could relieve pains; macrotin, dioscorein, and Hoffman's anodyne for pelvic cramps; aconite, acetanilid compound and gelsemin, for fever; warm baths, hot mustard foot and leg baths, cold applications for fullness of head; iodine and belladonna over ovaries; blisters to spine over tender points, and also over ovaries; with such other symptomatic treatment, as conditions of acute nature complained of, were described to me by the parents. Apomorphine and cold water duckings were not used. My directions for douches of hot salt water, were not carried out, the girl and parents never having used a syringe, were timid about the use of one. This on account of her condition at that time could not have benefitted her. I suspected some mechanical difficulty, and was very much disappointed, as I expected that should they attempt the douching, they would then discover her true condition. However, she used hot water douches, with the addition of carbolic acid and hydrogen peroxide, for dilating vagina and for relieving soreness, after atresia was removed.

A few days after her next effort to menstruate, the girl was



brought to my office for examination, on account of painful sickness, with cramps and nervousness, accompanied by severe pain in the back, spinal tenderness, and chorea-like symptoms. Pain due to dragging on broad ligaments from engorgement of uterus and ovaries, were referred to outer and inner sides of thighs. The mother says none of her brothers or sisters ever had fits or spasms, and chorea is not common among negroes. The mother gave same history of spells or spasms, and was much alarmed, as the girl did not have usual nasal hemorrhage, at period just before examination and dilation. Mother attributed the severe symptoms to this. Her excess of fat, I suspected as a cause for the amenorrhoea and dysmenorrhoea. On account of the fatty abdomen, external examination was not satisfactory, except to determine tenderness of uterus and ovaries, and apparent enlargement. Pressure caused pain. Before examination, bowels and bladder were emptied, morphia  $\frac{1}{4}$  gr., atropine 1-150 gr., hypodermically, were given thirty minutes before chloroform was administered, to allay nervousness and prevent necessity of more anesthesia than was otherwise required, as on account of her race and weight, I desired to use as little chloroform as possible. Chloroform was then given to moderate anesthesia, her mother pressing on abdomen to force uterus down.

On examination I found her normal in development, until vagina was examined, when she presented an imperforated hymen, without bulging or tenderness. Incision of hymen did not clear up her condition, and I proceeded to divulse with fingers, scissors, knife, and artery forceps, as it seemed convenient to reach uterus. When it had been pulled down with volsellum forceps, uterus appeared to have never been opened, as adhesions were up and around the neck, and no evidence of menses at any time were present. Retractors and fingers, with forceps, were used mostly, as speculum seemed to retard effort. Hemorrhage was not marked and was arrested by hot moist compresses of gauze or cotton. When groove director entered uterus, flow was apparent on director groove, whereupon, I dilated uterus to size of finger, and about a teacupful of dark menstrual blood and mucous, of a sirupy consistency, was drained away. This I suppose represented the menses for the preceding month, as she did not have any nasal hemorrhage at that time, and all other menses that remaining unabsorbed. After this draining a graduated probe was used to ascertain the probable size of uterus, which was found to be enlarged. Enlargement of ovaries and uterus was not as much as a retention of menses from the age of 14 to 18 would indicate, so that Nature

must have absorbed and eliminated. Some cases are reported of the accumulation causing rupture of vagina, uterus, ovaries, and tubes into abdomen.

A wick of 10% iodoform gauze was placed well into uterus; a tampon of cotton, with 10% iodoform gauze covering, and large rubber tube extending through tampon for drainage, was introduced; a compress of cotton covered with bi-chloride gauze and a "T" bandage with cotton, were applied. In this condition she was taken home, and instructed to continue previous medical treatment, with the addition of permanganate of potash and apiol, to be taken two or three days before usual symptoms appeared, and continued for three days, in order to better clear the uterus. She was also instructed to keep quiet, warm and clean, drinking what water she desired, and to be placed on a milk or other light diet. Light diet and salines were always indicated because of her plethora. In bed her shoulders were kept high on pillow.

The second day she was up and around the house, but was put back in bed. Her temperature was 100 to 102. Dressings being changed were found not badly soiled, and she was again douched and tamponed with drainage. The mother was instructed to occasionally insert a gelatin capsule of wool or cotton, saturated with dilute antiseptic solution, to prevent adhesion. Tampon to be placed high up in vagina. It was not necessary to use inter-uterine douche, as considered the use of carbolic acid and hot solution or hydrogen peroxide, or permanganate of potash hot solution, or hot mild bi-chloride of mercury followed by hot salt water douches, to be sufficient. Did not think it advisable to use astringent, antiseptic douching, on account of liability to increase atresia, and did not consider additional dilation or curettage indicated at any time, or other remedies required.

In about ten days from dilation, she was again up and around, feeling quite well, though still a little weak. I attributed some of her trouble after first day to getting up too soon. The same treatment was continued with symptomatic changes, and her first menstruation was free but painful. After first painful menstruation, I considered the use of numerous other treatments as required for such conditions, such as glycerine, hydrogen peroxide, solution of ichthyol, iodine, hydrastus, phenol solution on wool or cotton gelatin tampons, and also a saturated solution of magnesia sulphate, with glycerine, for depletion, but did not use these, as at her next menstruation period, she was normal. Her second menstruation was free and natural, and without pain. This has occurred regularly, every 28 days since, and her general health

has been good. She has not had a nasal hemorrhage or any sickness since, otherwise than constipation or cold, and this did not in any way effect her menses or nervous system, and did not cause severe cramping or leucorrhoea.

Therapy was applied in medium doses generally, between minimum and maximum to effect, according to physiological effect of drug used, not allowing combined dosage of synergistic drugs to exceed maximum dose of any one, drugs being given singly when possible, and active principles when possible, and as palatable as possible. The time intervening between doses of medicine used, was estimated according to reported time of drug effects, apparent to me, as stated by Potter, Foster, Bartholow, Butler, Shoemaker, and others usually consulted on therapeutics. Turpentine stupes were used through the day for plevic soreness and pains, on the second to fourth day, and hot cataplasma kaolini, at night, so as not to disturb her by frequent changing.

Her spinal and nervous condition was probably of a hysterical nature, as sphincters were not affected by loss or marked retention. She was previous to her vaginal menstruation, much more nervous at the term than at any other time; now but little difference. Nervous symptoms were all at usual time and did not appear epileptic, being secondary to prolonged cramping and pain, varied in severity from semi-conscious spasmodic twitching to convulsive in nature, each time becoming more severe. No aura or eye symptoms were known. Hallucinations, lethargy, catalepsy, globus or clavius hystericus, there was none. Delirium slight, and senses normal. No pupil or change of face color observed by the mother. At no time did I consider her amenorrhoea or dysmenorrhoea due to tuberculosis, cysts or tumor. Uterine cramps were naturally severe, as cause of them was not discharged by uterine contraction, and at no time did she complain of uterus causing tumor-like pressure on bladder or rectum.

The girl has not had any bowel trouble since dilation at birth, and is not usually constipated, which is evidence that rectal atresia must have been slight, or her pelvic troubles would have produced an obstinate constipation.

Pryor says, coincident with pain in dysmenorrhoea from ante-flexion, hysteria or hysterio-epileptic seizures may occur, and I presume in other cases, as severe uterine irritation from other causes may result the same. Lusk says, inability to perform sexual act often leads to discovery of vaginal atresia. Skene says, such women should not marry, as complete atresia always shows constant tendency to contract or adhere. However, nothing of

that kind has been reported in this case. Skene further says, when ovarian discharges are impaired, ovarian epilepsy is apt to occur. Other works could be quoted, but I consider my diagnosis of uterine irritation, producing convulsive symptoms, to be justified by the authors quoted, and consider the girl's condition congenital.

Previous to dilation, the girl was very reticent and bashful, especially with boys, but is not so since menses became normal. Am expecting more developments, as the girl intends to marry soon. Should she marry, would not her previous history be of some service to her physician in case of confinement. I have told her mother to inform her physician of these facts, should the girl become pregnant.

Of the numerous drugs and treatments for such conditions, I used only the usual, as I considered that if they did not relieve her, it must be mechanical.

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#### DISCUSSION.

DR. M. L. PERRY, of Parsons:—This paper brings out a great point in that we should look for peripheral irritation in such convulsive cases as described here. Whether or not this girl's condition was one of hysteria or epilepsy or what, she had a convulsive disease, and the cause seems to have been peripheral irritation. In all convulsive diseases it is well to make a complete examination to see if we cannot find some source of irritation. It has even proven that after having a very slight irritation it will produce decided results. I recall a case I had one time when I was in the general hospital. An old man came into the hospital for convulsions. His convulsions were of short duration, it had only been a short time since they were developed. He complained one morning about having a very sensitive tooth and I examined it and the least pressure on it would throw the old man into a convulsion, and I extracted his tooth, and he had no more convulsions during the time he was under observation. You see very often even slight causes will produce irritation and will be followed by a convulsion which may become fixed and chronic and pass into a fixed nervous disease.

DR. McCLELLAN, (closing the discussion):—I have nothing to say except in regard to temperature. While I have never had any personal experience I am satisfied from what I have seen in my own practice and what I have been told, we do have very erratic temperatures with these nervous spinal troubles.

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## STATIC ELECTRICITY IN THE TREATMENT OF NERVOUS DISEASES.

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By DR. A. HAGGART, Ottawa, Kansas.

Read Before the Franklin County Medical Society, May 27, 1908.

I come before this society with a few statements regarding static electricity, that have taken my best efforts to prepare. They come from twelve years of observation in electro therapeu-



tics, the last four years being spent in practical work along various electrical lines.

The electric treatment of today is a departure from the methods of twenty years ago, and very little attention was given to it by the general practitioner before the X-Ray came into use in 1895, and the demand for the different forms of electrical energy for the use of the Crooks tube became an absolute necessity, and thus the installation of either the static apparatus or the coil. As soon as the profession began to use a static apparatus, it became a factor in the treatment of various diseases, and the operators, after some practical work, found that in the many static currents they had a tonic, a sedative, a stimulant and a circulatory equalizer that was worthy of close observation and special attention. It has proven itself a superior remedy, and has entered the field of medicine and surgery,—not as a fad or like a dream to be forgotten, but to assist the general practitioner,—oftentimes when everything else has proven unsatisfactory. In many conditions where medical treatment has been given for years, and with little or no results, and in many conditions where there is not the proper response to drug action, electricity has given satisfaction.

To many people, certain drugs are poison, yet it is no wonder that some persons cannot even take quinine or some of the much used preparations without a complaint, when we stop to consider that some cannot eat some of the choicest foods without having some disturbance of the peripheral nervous system. Some are affected in this way by strawberries, others by various substances. In my own case, I cannot eat lobster without trouble. While in Washington last fall, I ate a very fine lobster and I had hives for thirty days.

When the circulation is equalized in a part, what is the effect? You restore these parts nearer to the normal condition when you give a patient static electricity with a very high pulse or a very low pulse, and after twenty minutes' treatment the pulse is close to normal. By actual count, you then have a right to say that the circulation has been equalized, and the patient must be nearer the normal than before. When a patient has a rise of temperature, or sub-normal temperature, and, on examination after twenty minutes' treatment, the thermometer shows a nearly normal temperature, do you not believe that the current has virtues that are worthy of consideration? And it certainly belongs to the general field of medicine, and not entirely to a few specialists, who treat a limited number who are able to pay the fancy price of \$5 to \$10 per treatment. It is within the reach of the masses at a price that

is reasonable to all,—especially the doctors in villages and small towns; they can use it side by side with their calomel, quinine, or other remedies, and I think today, electricity, as a remedy, is here to stay, because it has entered the ranks of the general practitioner. It has proven itself worthy of a place among the most important remedial agents.

I wish to call your attention particularly to the fact that electrical apparatus has been built during the past five or six years with modern improvements that makes a line of treatment possible that was unknown or unsatisfactory before these important inventions and additions were offered to the medical fraternity. Now, for example, take the current controller, invented and patented by Ed. C. Jerman, formerly of Indianapolis, now of Topeka, a man who has spent the best years of his life in perfecting an invention that makes it possible for the regulation of the dosage of current. He has solved a great problem in the regulation of the amount of current given the patient, and for this one thing alone he is a benefactor to the human race. Take away my current controller and it takes away 75% of my electrical business. The controller makes it possible for the administration of any of the static currents to a baby, a child, or an adult.

An engineer would not think of starting his engine by pulling the throttle wide open, neither does a doctor wish to pull the controlling rod out and turn on all the current in each and every case, so it was necessary that important changes be made in the apparatus before the doctor could operate the static machine with any degree of satisfaction. We have much evidence that the static line of treatment has entered the ranks of general practice.

My static machine was built by the Western X-Ray Co., of Topeka, Kansas. Their factory is equipped for the building of every line of electrical and mechanical apparatus. There are over 165 of this type of static machines in operation in Kansas. The men who are using this machine say they are getting satisfaction from the static current. I have visited many of them, and have investigated. Write any of these doctors, and ask them what they are doing and if they would sell their apparatus, and I doubt if any would give anything but a favorable report of the apparatus they are using, or of the results they are getting, whether it be with the static current, or the X-Ray. I have been amply repaid for my investigation. It is satisfaction to know that some one else is securing satisfactory results in the electrical line of work besides myself. "The proof of the pudding is the eating thereof." So it is with electricity,—the more you investigate, the better

satisfied you become that it has now reached a place in therapeutics, where its practical use appeals to the best judgment of the stronger practitioner. I do not depart from the teachings of our forefathers; I look upon electricity as an old time remedy that we have better control over today than ever before, and we are better able to administer it in its proper dosage, and thus we will be able to use it more frequently, becoming more proficient in the line of work for which it is particularly adapted. When I say that in my judgment, from my clinical experience, the static current is the best nerve tonic, I have said nothing more than the best authorities are claiming today. When I state that I believe it to be the best circulatory equalizer I voice the sentiment of men who are using static electricity, and in these two properties we have the foundation which form the prime factors in the treatment of diseases of the nervous system.

The various forms of static electricity can be used as a tonic, stimulant, or sedative to the cells. It has a special influence on circulation, nutrition, and metabolism. The chief seat of nervous metabolism is claimed to be in the axis cylinder, which is a continuation of the neuron substance. The axis cylinder of a nerve is the conducting or essential part of a nerve lying in the center and surrounded by the sheath of Schwann, and this axis cylinder is better protected than any electric wire, its coverings are more in number and finer than any insulated wire we can make. The neuron is the cerebro spinal cord taken as a whole and to be considered the important nerve center. Wm. Benham Snow, M. D., of New York says, "That static electricity, according to the method of administration employed, is characterized by several distinct qualities of action. Penetrating tissue and producing protoplasmic contraction, with a minimum of irritation, when the wave current, static induced current, the vacuum tube current are properly administered. They are, therefore, the measures par excellence in therapeutics for the dispersion of pathological stasis.

For the same reason as stated in the preceding observation, the same static modalities which mechanically induce tissue contraction, excite vibratory activities in torpid areas, stimulating to a great degree local metabolism, with re-establishment of circulation and tissue repair where stasis and impaired or obstructed elimination are present.

Another mechanical effect associated with the administration of the static modalities, administered with the patient insulated, is occasioned by the surging of the current from the point of surface of application of discharge. The effect of the passage of the

substantial electrons is to induce degrees of general metabolism which is evidenced by the marked increase of secretion and general awakening of functional activities.

Polarization associated with the passage to and fro through the patient of one polarity with an unidirectional current, induces effects in the tissues which coincidentally awaken in another way activity.

The actinic effects, in common with the high potential coil and static modalities associated with the radiations evolved within the vacuum tubes and the convective discharges (the effleuve, the brush discharge and the spray), are capable, in varying degrees, according to the volume of current involved, of destroying germ life superficially located, and in some instances to considerable depth within the tissues.

The phoretic action of the current administered with the vacuum tube is capable of forcing into the tissues minute particles of nitrous acid evolved by the discharges and other medicinal substances, rendering them valuable in the treatment of superficial infected conditions.

Muscular spasms of peripheral origin are locally relieved by the static modalities, either by the removal of sources of irritation, or direct action upon the neuro-muscular mechanism.

A broad conception of the indications for the employment of the static modalities would indicate their use in all non-infected, inflammatory conditions, internal and external, and for the energetic re-establishment of local and general metabolism. The following special indications are conserved by them:

The static spark and static wave current, and to a less degree, the brush discharge, and the direct vacuum tube current, are the means par excellence for the treatment of all non-infectious joint inflammations.

In the treatment of uncomplicated neuritis in regions accessible (the only exceptions being with the pelvis, chest wall and bones of the skull), the static wave current, static spark, brush discharge, and direct vacuum tube current, alone or in combination, are uniformly effective in skilled hands and the choice of methods in those cases.

In the treatment of spinal cord affections of a non-infectious inflammatory character including tabes, anterior poliomyelitis, myelitis, syringo-myelia, and the dystrophies, the static wave current to the spine and sparks to the periphery, in adults meet the conditions present, to affect which they must be applied with



great energy over the site of the lesion of the cord and without fear.

In the treatment of pelvic and genital conditions, non-septic in character, the static wave current, and direct vacuum tube current, are effective in the following conditions: Uterine congestions and dysmenorrhea, subinvolution, cervical-ulceration, salpingitis, ovaritis (usually secondary) urethral caruncles, hemorrhoids (not indurated), fissure in ano, rectal ulcers, prostatitis (not removing hyperplasia), vesiculitis (specific and non-specific), congestions in the spermatic cord and canal between the internal and external rings, epididymitis, orchitis, chronic gleet, and impotency in many cases. In all of these cases named those modalities are more effective, safe and cordially to be recommended.

In the following glandular congestions, either the wave current or direct vacuum tube current are the choice of modalities. In enlarged and congested liver, spleen, simple adenitis, in simple mastitis, and tonsillitis before suppuration has advanced, over the pancreas in diabetes, the kidneys in Bright's disease, the adrenals in Addison's and the thyroids early in simple goitre and Grave's disease, over the stomach, duodenum and ileum when secretions are abnormal or deficient; over a dilated stomach and constipated bowels. In the above conditions the static modalities are very effective, more so than other agents in most cases, because by inducing active, energetic, intrinsic contraction, they remove congestion and infiltration and restore tone and metabolism.

Conditions of spasm or muscular contraction are relieved by the static modalities, particularly by the spark and wave current. Either through the secondary effect of relieving congestion, as when associated with joint diseases, in dysmenorrhea or vaginismus, or by the direct antispasmodic influence in other conditions, as in high arterial tension and acute spasm, as in muscular cramp.

On general and local metabolism, when not complicated by organic disease, the static modalities, particularly the wave current are remarkably efficacious and indicated as part of the treatment in all cases, because all of the functions are demonstrated to be quickened, weight increased, hemoglobin percentage is increased, an approach to normal in the blood count induced, all due, undoubtedly, to a quickening of cell activity throughout the economy, owing to the stimulating influence of the passage everywhere of the rapidly moving electrons.

I also wish to call your attention to an article by Dr. Samuel G. Tracey, of N. Y., in the New York Medical Times. He says: "While subjected to the electric action the system is ener-

gized, the circulation of the blood equalized, the blood pressure is reduced, the general nutrition is improved, functional activity stimulated, the proper relationship between waste and repair is better sustained, and at the same time the elimination of poisonous products takes place more rapidly. After repeated applications Nature resumes her own work without electrical stimulus."

Kassabian, in his recent publications, claims that the static modalities effect the circulatory, respiratory, nervous and vaso-motor systems. Its action on the circulatory system is to lessen arterial tension, lessen the heart frequency, lengthen diastole and increase pulse volume. The effect on the respiratory system is relief of rapid and labored breathing; also deepens the breathing with increase in elimination of  $\text{CO}_2$ . Its effect on the nervous system is to relieve irritability and to reduce soporific effect.

The effect on the vaso-motor system is to induce diaphoresis, also diuresis with increased amount of urea and increase in general metabolism.

The therapeutical value attached to static electricity is recognized by many of the best medical men of today—men in our own country whose sincerity cannot be doubted, as Drs. Morell, Pusey, Morton, Massey, Newman, Gottschalk, Snow, Hirdman, and many others too numerous to mention. Dr. William J. Morton, of New York City, in 1880, was a student of Charot. Static electricity was at that time his principal teaching. Dr. Morton returned from Europe about this time bringing with him two static machines, the first introduced in America. In 1899, Dr. Morton, at the suggestion of his associate, Dr. William Benham Snow, published facts of much interest to the medical profession, treating of various currents derived from a static apparatus, among these the wave current, the arrangement of which is essentially that of a transmitter of wireless telegraphy. Such an arrangement sends Hertzian waves from the patient's body. This wave current is a very important factor in the treatment of the diseases of the nervous system, particularly in diabetes, and I expect you will agree with me in suggesting that diabetes is largely a disease of the nervous system.

I believe almost every doctor who is using the static treatment has received more satisfactory results from a larger percentage of cases, by its use, than by any other remedial agent, and considers it an important factor in the treatment of nervous diseases.

**PUERPERAL ECLAMPSIA.**

By DR. T. D. BLASDELL, Garnett, Kansas.

Read Before the South East Kansas Medical Society.

By the terms eclampsia, puerperal eclampsia, and puerperal convulsions is meant in modern medicine an acute morbid condition, making its advent during pregnancy, labor or the puerperal state, and is characterized by a series of tonic and clonic convulsions, affecting first the voluntary and then the involuntary muscles, then complete loss of consciousness, and ending in coma or sleep. It may be the gestational intra partum, and post partum, or puerperal eclampsia proper.

The word eclampsia comes from the Greek word, meaning (to flash out).

There is nothing which excites more consternation among the relations of the lying-in woman than the supervention of puerperal eclampsia.

When the practitioner is brought face to face with this affection, he can but feel that he has to encounter, a condition of great gravity since Edgar and Barnes and other able observers has put down the mortality at from 25 to 30%. As to the frequency of occurrence it is shown to occur in one case in every 250 to 500, 2 to 4% and some authors say 25% of all pregnancies.

The etiology of this disease is still obscure, but there are numerous theories now as of old; some of the most common are, all forms of nephritis, retention of urine, constipation, and extended and exhaustive expulsive efforts. Eclampsia occurs more often in primiparae than multiparae, the ratio is 3 to 1. It seems to me that the first theory, namely, nephritis as an involvement of the kidneys, holds good in more cases than any other.

When we stop to think that we have an involvement in two thirds of the cases and in 84% we find albumen in the urine.

The urine also generally contains slight traces of sugar, red and white blood corpuscles and casts, we have symptoms of acute congestion of the kidneys.

This theory is advanced by some, that the alterations are not inflammatory but degenerative in character, the renal epithelia, undergoing a fatty infiltration. Those who survive the eclamptic state, the kidney undergoes resolution. It is well known that albuminuria is not always present. The pathology is still obscure but we find an anemic condition and congestion of the cerebral cortex and in some cases apoplexies of the liver and a fluid condition of the blood. But the most noted alterations are "A de-

creased urinary toxicity and an increase in amounts of the poisons circulating in the blood."

It is therefore a toxemia due to some undiscovered agent, present under certain unknown conditions in the body, at the time, just before, during or shortly after labor.

The causal factor may be bacterial, it may be of placental or fetal origin, may arise from faulty metabolism, with absorption of resulting poisons, or the abnormal absorption of normal metabolic products.

Summing up the characteristic pathological findings from a review of the literature, the kidneys always show evidences of degeneration and the liver is studded with punctate hemorrhagic thrombi and degenerate epithelium.

The mucous membrane shows punctate hemorrhages and necrosis of the epithelium. Similar lesions are found in the heart; not so frequently in the suprarenals, pancreas and gastro-intestinal tract.

**SYMPTOMS.** The symptoms are many and may be divided into two classes, prodromal and active.

In the prodromal symptoms we usually have a well defined aura, headache, tinnitus aureum, dimness or total loss of vision, dizziness, flashes of light before the eyes, vertigo, epigastric and nervous disorders, contracted pupil, odema of the face and finally and of first importance the presence of albumen and casts in the urine. We now come to the active symptoms, which if once seen will never be forgotten. It usually begins with convulsive jerking of the orbicularis muscle, giving a smiling appearance to the patient, a jerking of the eyelids, the eyes become fixed and pupils dilated, face cyanotic, rapid jerking of the muscles about alae of the nose and mouth, the mouth is drawn to one side, rotation of head and rolling up of the eyeballs. Now we have tonic and clonic convulsions, passing from head to all parts of body. The head and mouth is drawn to one side at first and then backwards and with the back forms the opisthotonic curve, extended and rigid arms, closing of fingers, with thumbs in the palms, the tongue is partly protruded and may be bitten and there may be a bloody froth exuding from the mouth and stertorous breathing, have complete loss of consciousness and sensation.

The tonic convulsions usually last from 10 to 20 seconds.

Between the convulsions the patient may have to be held in bed. If we cannot control these seizures death will be inevitable.

When death supervenes we have a small rapid wiry pulse,



with a rise of temperature of from 103 to 104°. They may go from the convulsive state into the comatose condition.

Consciousness and sensation are slow to return.

**TERMINATIONS.** If the fetus is expelled the attack ceases or diminishes in frequency and intensity and coma passes into gentle slumber. The patient on awakening will have no recollection of the perils through which she has passed, but the danger is still not at an end, as the patient is still predisposed to post partum hemorrhage and to puerperal inflammation.

In fatal cases death is due to carbonic acid poisoning.

**DIAGNOSIS.** This is not difficult if a thorough study is made of the patient.

There are several diseases which simulate it, among which are epilepsy, hysteria, apoplexy and meningitis.

In epilepsy there is a history of former attacks, and the characteristic fall and cry. Hysteria, there is consciousness at all times, apoplexy, there is no prodroma, it comes suddenly and rarely during pregnancy. Meningitis, very rare, and spasms are local and may have paralysis of certain limbs.

**PROGNOSIS.** This is still a very grave affection, statistics show at present, maternal mortality 30 %, child mortality 50 %.

**TREATMENT.** The bi-monthly examination of the urine of pregnant women is to be regarded as an indispensable precaution, persistent albuminuria calls for special prophylactic treatment.

The theory that is accepted by the majority of the able writers at the present time, is that eclampsia is due to a toxemia. Then our treatment should be along these lines, we will have no specific treatment so long as the pathology is obscure.

The prophylactic treatment of eclampsia is far more important than the curative.

First as to diet, what foods act as an irritant to the circular fibers? The nitrogenous foods.

Limit these as much as possible. Milks should be the basis of food in this disease, it is the very mildest nitrogenous.

Rare cooked beef steak or mutton is very easily digested, if the starches and carbohydrates produce fermentation, then stop them at once. Vegetables, those richest in water. Eggs and easily digested fats, butter, well cooked crisp bacon. Should be encouraged to drink plenty of water.

Elimination should be brought about by the energetic stimulation of the fine eliminative processes as follows: bowels, kidneys, liver, skin and lungs. For the bowels, daily doses of colocynth

and aloes at evening followed in the morning by one of the saline cathartics; kidneys, large doses of nitrto glycerine, liver, an occasional dose of calomel and soda at bed time, skin, warm baths and massage.

We may have indications for the induction of labor when prophylaxis fails or the pre-eclamptic symptoms become urgent.

The statistics show that when this measure is resorted to that most of the mothers recover and 75 % of the children live.

We now come to the **CURATIVE TREATMENT**. The eclamptic seizure presents a very grave condition, there are many remedies which we have to pick from but no one treatment can be recommended for all cases, many women recover and many die in spite of treatment.

First control the convulsions, the "sheet anchor" for this is chloroform. Chloral per rectum is also good. For elimination, 1 to 3 drops of croton oil mixed with glycerine placed on back part of tongue.

Hypodermo clysis with saline infusion is not indicated during convulsions, because the heart is laboring violently to empty its blood into the aorta and pulmonary artery, but is largely prevented by the respiratory spasms. Veratrum viride is very good to use in convulsions to relax the arterioles and slow the pulse it should be given in doses of from 10 to 15 drops, hypodermatically every half-hour until the pulse is brought to 60 or below.

Venesection is not resorted to so frequently as it was, but may be used to reduce the toxicity. It might be well to try thyroid extract when other methods fail.

As the last resort, produce premature labor.

In conclusion I want to emphasize two things: First—We can prevent a large majority of cases by careful application of the knowledge we possess, and, Secondly—That in the treatment of cases, each must be a law unto itself.

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## OPSONINS AND AGGLUTININS.

By DR. L. R. SELLERS, Osawatomie.

Read Before the Kansas Medical Society at Iola, May 7, 1908.

The studies of the last twenty years have disclosed the definite relations of bacteria and a long list of well known diseases. Such a list includes the following: anthrax, cholera, croupous pneumonia, diphtheria, glanders, gonorrhoea, influenza, leprosy, relapsing fever, tetanus, tuberculosis, typhoid fever, and various

wound infections—including septicaemia, pyaemia, acute abscesses, ulcers, erysipelas, &c.

Pathogenic bacteria are every where present—in the food we eat, the water we drink, and in the air we breathe. Fortunately, the living body at all times possesses substances called alexins, that antagonize bacteria and quickly destroy them if they by chance should gain an entrance into the body. Sometimes, however, when bacteria enter the body the alexins are unable to dislodge or destroy them. Then the white corpuscles of the blood take up the battle. They rally at the point of invasion in vast numbers—will even work their way through to the outside of the blood vessel to engage the foe. Each white corpuscle will eat and destroy a score or more of the disease producing germs. As a rule bacteria locate in some special part of the body. Each specie has its own particular location. Thus, the bacillus of typhoid fever locates in certain glands of the intestines, and are sometimes found in the liver, and also in the spleen. The bacillus of tuberculosis locates in the lungs, joints or mesentery. The bacillus of diphtheria on the mucous membrane of the throat, and when once located, they remain in the place chosen, and if not destroyed by the phagocytes, reproduce their specie and rapidly multiply in numbers. When the colony has become large, the bacteria secrete bi products which are highly poisonous to the system. The alexins and phagocytes have failed to prevent their establishment, and since the opposition was overcome, it would appear that they would rapidly increase in numbers until the patient succumbed. And such would probably be the case, were it not for the fact that this poison secreted by the bacteria develops in the body of the patient new cells that secrete antitoxins that destroy the poisons, and agglutinins, and opsonins which in various ways overcome the bacteria. Thus the bacilli in the throat of a patient afflicted with diphtheria, are pouring out a poisonous secretion that is taken up by the blood and poisoning the body. The tissues of the body rebel against this toxin and develop special cells which secrete an antitoxin that quickly neutralizes and destroys the poison generated by the bacteria. And in every case, if the patient lives, it is only a matter of time that cells are developed to secrete sufficient antitoxin to destroy the poison, and weaken the bacteria to a degree that the phagocytes may destroy them. But as this takes time, and the patient is liable to die before the antitoxin cells are developed. Hence the advantage gained in using artificial antitoxin. This is prepared as follows: A culture of bacillus diphtheria is made, and when a quantity of the poisonous bi product

is produced, this (and not the bacteria), is injected into the circulation of a healthy horse. This poison causes the horse to develop special cells that secrete an antitoxin, and when its blood is saturated with it, a portion of the blood is drawn, and the serum which contains the antitoxin is injected under the skin of the diphtheritic patient. The typhoid bacillii when colonized in the body secrete a poison which produces the fever and other symptoms of the disease. And this poison causes the system to develop cells that secrete opsonins and agglutinins. The agglutinins cause the bacteria to clump together and die. When these cells are developed, they go on secreting for many years, often as long as the patient lives. Hence, as a rule, one attack of typhoid fever renders the patient immune the remainder of his life—because he has developed cells that continue to secrete opsonins and agglutinins, which prevent the specific bacteria of typhoid fever from entering and growing in his body. In typhoid fever, these protective cells usually develop early in the disease. At the end of the first week, sufficient agglutinin may be secreted by the new cells to produce Widall's test. This test is conducted as follows: A culture of typhoid bacillii is made, to ten drops of this culture containing myriads of bacteria, is added one drop of patient's serum, or one drop of blood, and if the bacteria in the course of ten to thirty minutes clump together, we know that the patient has cells that are secreting agglutinins—and consequently now has typhoid fever, or has previously had the disease.

But we must not lose sight of the phagocytes, they are all the time busy, but certain forms of bacteria are too powerful for them to encounter. We have seen infected wounds secreting a brownish fluid, not a phagocyte in the vicinity—the bacteria being so formidable that the phagocytes kept their distance from them, and the bacteria rapidly increased in numbers. But their poisons thrown into the system caused the development of cells that secreted material which weakened the bacteria to such an extent the phagocytes were able to eat and destroy them. These substances are called opsonins, the meaning of the word is—to cater; to prepare food. So the opsonins prepare the bacteria in such a manner that the phagocytes are able to make food of them. In the majority of people, the phagocytes are able to meet and speedily destroy the tuberculous bacillii as soon as they enter the body. But in others, the phagocytes are too weak to encounter and destroy the invaders. This power of the leucocytes to destroy bacteria, is expressed as the opsonic index. To measure the opsonic index, a little blood is drawn, diluted with sodium citrate and



centrifugalized, so that the white corpuscles are obtained in a layer. Then some white corpuscles are mixed with a suspension of tubercular bacilli and the patient's serum. The mixture is placed in a thermostat for half an hour, after which, a smear preparation is stained and the number of bacilli ingested by fifty phagocytes counted; then divide this number by fifty, the quotient will be the average number of bacteria ingested by each phagocyte. Now if the average number of bacteria engulfed from the patient's serum is only ten, while the same phagocytes, with the same bacteria, but with normal blood serum yield a preparation in which the average number of bacteria ingested is twenty, counting the normal blood as one, the patient's opsonic index would be .5. This shows that the weakness is not in the patient's phagocytes, but that his blood serum lacks something necessary to prepare the bacteria for ingestion—or in other words—a deficiency in opsonins.

It is now conceded that the termination of all bacterial diseases, and immunity for the same, depend upon the development of cells that secrete antitoxins, opsonins, and agglutinins. Recently many experiments based on these principles have been conducted in the effort of preventing diseases, and also of mitigating the severity of diseases when contracted. Four methods have been applied for active immunization of persons against infection: 1. Innoculation with virulent pathogenic germs. 2. Protective inoculation with attenuated pathogenic germs. 3. Protective inoculation with bacterial extracts. The first two methods are now but little used—almost the sole example of the second is vaccination against small pox. In all other cases of active immunization, the exciting agent is a product obtained from the bacteria of the given disease. Encouraging reports come from all parts of the world. The immunization against cholera has been obtained in many thousand cases. Innoculation for prophylaxis of typhoid fever, has been very successful. The proportion of the inoculated who are attacked with typhoid fever, compared with those who have not been inoculated is about one third. And of these the fever runs a much milder course, and the relapses were less numerous.

The British army will not enlist a soldier for the African service unless he has been inoculated for prevention of typhoid fever.

Last very many inoculations for prophylaxis of cholera were made, results reported satisfactory. In therapeutics, two classes of serums are used—one an antitoxin—that quickly destroys the poison and terminates the disease. The other builds

up protective cells that secrete bactericides in the form of opsonins and agglutinins. We have antitoxins for only three diseases—diphtheria, tetanus, and snake poison. The diphtheria antitoxin is eminently satisfactory. It has robbed the dread disease—diphtheria—of all its terror. The antitoxin for snake poison is successful, however, different species of reptiles require different antitoxin to neutralize their venoms. The antitoxin of tetanus is reliable, if given sufficiently early in the disease, unfortunately, when the clinical history makes the diagnosis easy, it is then often too late to receive benefit from antitoxin. From reports in medical journals, it appears that during the last two or three years, the theory of building protective cells to modify disease has been put into practice in many parts of the world. Last year one physician reports having treated twenty-five cases of pneumonia with Pane's antipneumonia serum. The results he observed were: that while the serum did not shorten the disease, it mitigated its severity in a marked manner. The temperature in every case dropped from one to three degrees; in every instance the patient expressed a feeling of relief; when cyanosis was present, it disappeared soon after the serum was administered. The serum treatment of tuberculosis is being used in all the sanitariums of the country. It is conceded that when the patient's opsonic index is high, the phagocytes have their best opportunity. When the opsonic index is low, it can be raised by injecting small quantities of dead tubercular bacilli, or extracts obtained from them. The good results of this treatment is most marked in cases of tuberculosis of joints—when the opsonic index is raised to a high point the phagocytes are able to destroy the bacilli. The good results following Bier's hyperaemia, is probably due to increased emigration of phagocytes to the infected part. It is claimed that in dysentery serum exerts a marked effect on the disease, in one or two days, the blood and mucous disappear; pain and tenesmus cease; the mortality is reduced one third. After typhoid fever has been contracted, antityphoid serum lowers the temperature; the patient's general condition improves rapidly, and mortality is greatly reduced. These reports on serum therapy are encouraging, but the antitoxin is the ideal remedy—while at present we have but three brilliant men in many parts of the world are devoting their lives in the effort of producing more, and we have reason to hope and believe they will<sup>very</sup> be successful in their ambitions.

#### DISCUSSION.

DR. H. L. CHAMBERS, of Leecompton:—I have been a good deal interested in this paper, in fact, I am interested in this subject. The loca-

tions are very simple in this matter, I am afraid too simple. For some time I have been trying to find out something about it from somebody that probably knew as to what is the source of the anti-body, whatever it might be. The doctor gets up here and very calmly assures us that a new cell is produced, that the action of a toxin of bacteria in the body causes the development of a new cell which produces the anti-body, whatever that is. That is a simple thing and tremendously important if it is true, but I say to you frankly this is the first time I ever heard of it, and I don't know about that, he don't have any way to show. I would like to see them, I would like to know how to find them. He says the opsonin is a kind of cell that secretes an anti-toxin that acts on the bacteria and puts it in such a position that the phagocyte can devour it. He says we have opsonins against several things, like snake poison. I don't see how we could have an opsonin that would have any effect against snake poison. I would like to have that explained. It seems to me the doctor perhaps has used this word in rather a loose sense, sometimes I think it means one thing and sometimes I think it means something altogether different. It seems to me that the whole work of the opsonin and the whole structure built up on the theory that is going to revolutionize the practice of medicine assumes that all immunity depends on phagocytes, which is not to be admitted. Vaughn says he now recognizes three sorts of immunity, an anti-toxic immunity, such as we have against diphtheria and snake poison and against tetanus, and phagocytic immunity where the opsonin would give off what he calls a (leucocyte) depending on the state of affairs that causes the supplying part of the toxic product of the bacteria. He discusses this with reference to hypersensitiveness, showing it is too extreme for such conditions; simply the same thing, that you have gone around the circle in opposite directions. I would like to have the doctor elucidate something about these cells that produce all these things and to reconcile the seemingly opposite uses of the word opsonin.

DR. — COMPTON, of ————:—I wish to rise merely to complement the doctor on his courage in presenting to this society a subject which I think is worthy the serious attention of every thoughtful physician. The doctor has introduced here the very latest theory in medicine, one that is in its infancy, and one which I believe will some day become one of the most potent factors in the treatment of disease more than any other up to the present time. It bears the same relation to the infectious diseases as does the neuron theory to nervous diseases. I want to compliment him on undertaking such a subject as this because it is a lesson to us younger men. I believe there are three classes of physicians: Those who read, those who don't read and those who don't pretend to read. I believe he has demonstrated that he is one of those who reads.

DR. SELLERS, (Closing the discussion):—I think the doctor misunderstood me when he said I classed snake poison as an opsonin. Snake poison is an anti-toxin. As to the location of those cells, I don't know where they are; I might put the question back to him: If a man has small-pox and he never again has it, he is immune, and I might ask him why he is immune, and probably he could not answer. This is a subject of large importance, and of course, you all understand this is simply a compilation from medical journals and our latest text books on this subject of opsonins and agglutinins and anti-toxins. I am sorry to say I have never invented anything in medicine, and furthermore I confess I have not learned all that other men have invented, but this is a subject that is of great interest to me, and I believe in 10 or 15 years that these theories advocated by Reed, Koch and Pasteur are going to revolutionize the practice of medicine. And there is one thing that is a marvel to doctors: they have gone on and they treat diseases and after the advancement of science,—we treat diseases, we use their remedies, and science comes in and tells why. Here comes along France,—they say that quinine is a parasite, and furthermore there is a lot of good physicians that use a little quinine for everything, and a man comes in with a coated tongue and is given some quinine and sent off, the doctor says "Well that man has got malaria germs in his circulation, but the scientists point out that quinine is an opsonin, it weakens the vitality of many species of bacteria, and the man that gives quinine for everything is not very

far wrong scientifically; and these men found all those things out, and science comes along, and it has occurred after we have gone ahead it has demonstrated and given a reason why we use this medicine. We used it before the advancement of science, we were taught those medicines were good. As an illustration you hunt for the gonococci and you hardly ever find them free, but take a dead leucocyte and each one has 10 or 15 or 20 gonococci that the dead leucocyte took them up and died.

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There was a good attendance at the September meeting of the Shawnee County Medical Society held in Topeka, Sept. 7th.

Dr. S. T. Millard reported a case with paralysis, aphasia and trophic disturbances.

Dr. J. R. Fay reported a case of fistula of 28 years duration following compound fracture, with recovery after removal of necrossed fragments of bone.

Dr. O. A. Taylor reported a case of left sided appendicitis, operation refused and case ending fatally.

Dr. Ida C. Barnes presented a paper on High Potential Currents and Low Frequencies.

The Secretary was directed to forward to the Information department of the A. M. A. the medical advertisements appearing in this county.

Dr. M. C. Porter, formerly of Clay Center, Kans., and Dr. H. P. Knowles were received as new members into the Society.

J. B. TOWER, Sec'y.

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The following people from this state are going to the International Congress on Tuberculosis which meets at Washington; D. C., from Sept. 21 to Oct. 12: Mrs. Eustace Brown, Olathe; Dr. S. J. Crumbine, Topeka; Dr. C. W. DeMott, Independence; Dr. M. T. Dingess, Atchison; Dr. F. A. Eckdall, Emporia; Dr. S. C. Emley, Lawrence; Dr. G. R. Gage, Hutchinson; Dr. C. C. Goddard, Leavenworth; Dr. G. M. Gray, K. C.; Dr. J. L. Grove, Newton; Mrs. C. B. Hoffman, Enterprise; F. L. Knapp, Topeka; Dr. E. E. Ligget, Oswego; Dr. E. J. Lutz, K. C.; Dr. E. B. Payne, Ft. Scott; Dr. M. Trueheart, Sterling; Dr. F. N. Schoenleber, Manhattan; Dr. C. B. Van Horn, Topeka. The Committee on Prizes of the congress has appointed Dr. S. C. Emley and Dr. C. C. Goddard as judges of whom there are 85 from the different nations represented.

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The Kansas State Board of Medical Examination and Registration will meet at Topeka, Oct. 13, 14 and 15th.

R. A. LIGHT, M. D., Sec'y.



# THE JOURNAL

## OF THE

# Kansas Medical Society.

JAMES W. MAY,

EDITOR.

J. E. SAWTELL,

ASSOCIATE EDITORS

CHAS. S. HUFFMAN.

Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

**OFFICERS OF THE SOCIETY.**—C C. Goddard, Leavenworth, President; E. E. Liggett, Oswego, 1st Vice-President; G. W. Goss, Sedan, 2nd Vice-President; B. M. Barnett, Roedale, 3rd Vice-President; Charles S. Huffman, Columbus, Secretary, L. H. Munn, Topeka, Treasurer.

**COUNCILLORS.**—1st Dist., Chas. W. Reynolds, Holton; 2nd Dist., H. B. Caffey, Pittsburg; 3rd Dist., F. M. Daily, Beloit; 4th Dist., O. J. Furst, Peabody; 5th Dist., O. P. Davis, Topeka; 6th Dist., J. A. Dillon, Larned; 7th Dist., Preston Sterritt, Kansas City; 8th Dist., A. L. Cludas, Minneapolis.

## EDITORIAL

The vicious practice of allowing a jury of laymen to decide the question of a persons sanity is certainly a relic of the dark ages. This system is in vogue in this State and to make matters worse no one is paid unless a verdict of insanity is reached. We should see the Representatives from our district and have them correct this evil at the next session of the legislature.

—O—

Shall we use the ophthalmomo-tuberculin reaction? Reports are being made by many investigators showing the danger to the eye from the serious after effects. Gorlich (in the Muenchener Medizinische Wochenschrift, June 30, 1908), says there is a great deal of danger in its use and he does not consider that the test is one which should be recommended to the practicing physician. In the light of these events, is it not subjecting the patient to too great a risk to use the ophthalmomo-tuberculin reaction?

—O—

The time is not far distant when this Journal will eliminate its questionable advertising and follow the recommendations of the Council of Pharmacy of the American Medical Association. To compensate for the loss which will be sustained by this pro-

cedure, every member of our society should interest himself in helping to get reputable medical colleges, hospitals, sanitariums, medical book publishers, ethical pharmaceutical manufacturers, surgical instrument makers, etc., to advertise in its columns. You are stock holders in this Journal and, as such, are interested in its welfare. By helping just a little, it will not be long until the Journal can support itself by the advertising alone.

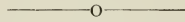
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Are we not too easily influenced in adopting the "new" things in medicine? For instance, in anaesthetics many have cast aside ether anaesthesia for scopalamin—morphin—cactin, when the percentage of deaths from the former has been proven by Woods to be but one in 16,000. The same author has proven that the mortality in the latter has been one in 300. There may be instances when scopalamin-morphin-cactin anaesthesia is preferable, but it is safe to assume that it will not supplant ether. This is also true of the spinal injection of tropo-cocain. There may be a few instances when it is advisable, but it is hardly probable that it will reach the universal usage that ether or even chloroform has. There is another fad that had an almost unprecedented run. It was an intestinal antiseptic purported to be many times stronger than corrosive sublimate, yet when taken into the system was harmless except as to its bactericidal powers. It was supposed and exploited to be almost a specific for typhoid fever, and attained enormous success as to sales but clinically was a failure. Let us be conservative in medicine as well as surgery. This is not meant to carry the idea of non-progressiveness. There is plenty of room for every good, new idea, no matter whether in medicine or surgery.

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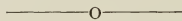
The suicidal mania has reached alarming proportions in the past few months. It has been steadily growing worse until lately it is impossible to scan a metropolitan newspaper without finding a report of one or more suicides. What can be the cause? One thing is certain, we are living a faster life than nature intended. Too much excitement, trouble and worry followed by a nervous breakdown. Life is taken too seriously and when reversals are suffered the will power is lacking to overcome them. The newspapers are also greatly at fault in publishing lurid accounts of the suicides. It sets one who is on the border-line of suicidal mania to thinking that here is a simple way to rid himself of his trouble and the deed quickly follows the thought. It is also far too easy to obtain the means for self destruction. The druggists as a rule do not give the

matter a thought and consequently carbolic acid, morphia, strychnia and other poisons can be purchased as easily as sugar, salt or other commodities. The marriage of first cousins and mental defectives such as epileptics which is prohibited by law in nearly all states is another cause. What is the remedy? First, have the newspapers (if it is possible to do so) exclude all "write ups" of suicides. Second, enforce the law in regard to selling poisonous agents to minors and enact one making it harder for any one to purchase them. Third, enforce rigidly the law prohibiting the marriage of first cousins and mental defectives. Also when called into a case of melancholia or where there is any probability of self destruction have them kept under restraint until all danger is past.



How are we to collect our fees and avoid the "dead-beats?" This question is a paramount one with every practitioner of today unless he is possessor of enough of this world's goods to be independent. It is almost a notable fact that there are but few medical men who have attained to the rich class and a large percentage of the latter have made their money in the commercial world. One reason for this is the large amount of accounts placed upon his books to remain there until outlawed and cast aside for fresh ones. If every physician were paid for actual work done perhaps there would be more time for scientific research and investigation. Every one does more or less charity work and, of course, this class of practice is not classed in the category of bad accounts.

What is the remedy for this problem? A "dead-beat" list is contrary to law. Collection agencies are but little improvement, for many physicians have had a harder time collecting from the agency after they had collected from the patient than from the patient himself. To be in court suing a garnishment is too expensive except in selected cases. Why could not a Physicians' Collection Agency, run and controlled by the physicians, be organized for such a purpose and contribute a portion of all moneys collected by said agency to pay attorney's salary and collectors? Surely the moral effect to be gained would be considerable, for it would not be long until many of the bad pay patients would pay up through fear of being made to do so by the court procedure and the publicity accompanying it.



#### FREDERICK STEARNS & CO., "PATENT MEDICINE" VENDORS.

Physicians who attended the Chicago session of the American Medical Association doubtless noticed while riding on the street cars the blatant

advertisements of the headache remedy SHAC (Stearns Head Ache Cure). This nostrum, which seems to have been responsible for at least two cases of poisoning, is put on the market by Frederick Stearns & Co., Detroit—a fact that was noted in these pages a few months ago. It was not unnaturally assumed that these Peruna-like advertising tactics had been adopted by an enterprising local representative anxious to make a “showing.” The June issue of the *New Idea*—a monthly journal published by Frederick Stearns & Co. and devoted to advertising their products to retail druggists—shows that this assumption was not well founded. In their journal they inform the druggist that “a new series of SHAC street car cards are now ready for use in the large cities.”

The evils of the indiscriminate use by the public of such powerful and insidious drugs as are contained in the various headache remedies need no further iteration. The question has long since ceased to be an academic one and no casuistic reasoning nor specious arguments can hide that fact that enormous harm is being done by the exploitation of these acetanilid-containing nostrums, and the medical profession has expressed itself in no uncertain tone regarding the matter.

SHAC, however, is not the only “patent medicine” put on the market by Frederick Stearns & Co. Just as extensively advertised—and in the same mediums; the street cars—are Zymole Trokeys “for husky throats.” Then there is Pam for the dyspeptic, a “tiny tablet of wonderful power,” of which the modest statement is made that “every ferment of the digestive tract that is available is used in these tablets, fitting them for use in all kinds of indigestion.” Surely, with such drugs at their command, dyspepsia need give physicians no further cause for worry!

These are some of the products put on the market by Frederick Stearns & Co. and vigorously “pushed” by them in advertisements to the laity. A firm which, while soliciting the patronage of physicians through the pages of medical journals, is at the same time furthering the interests of self-drugging and dangerous nostrum-taking, will be looked on with distrust and suspicion by the medical profession.—*Journal A. M. A.*

And to think that the medical profession has supported and kept alive this institution. Supposing all of the profession should withdraw their support from the institutions of this like it is easy to see the outcome. The time will come when physicians will stand together and that time is not far distant. Lets open our eyes.

—o—

## CLINICAL NOTES

It is unwise to use bichloride solutions in the eye for a protracted period especially where the patient can not be watched, as it is liable to form a permanent opacity in the cornea—This rule holds good with solutions as weak as 1 to 5,000.

—o—

**Enema for Relieving the Bowels in Intestinal Colic.**—At the House of Relief of the New York Hospital the following enema is given for the relief of intestinal colic:

R̄ Oil of turpentine,	3ii;
Oil of cotton seed,	3ii;
Tincture of green soap,	3ss;
Water, enough to make,	Oii.

To the mixture formed by the first three ingredients add one pint of hot water, to be followed by sufficient additional cold water



to make the whole measure two pints. The best results are obtained by using a bulb syringe and soft rubber rectal tube, inserting the tube high up.—N. Y. Medical Journal.

—o—

**Gargle for Quinsy.**—According to *Journal de médecine de Paris* for June 27, 1908, Guisez uses the following gargle in the treatment of amygdalitis:

R̄ Carbolic acid,	.....	℥ xv;
Glycerin,	.....	℥ iss;
Menthol,	.....	gr. v;
Cherry laurel water,	.....	℥ v.

M.

Sig.; A tablespoonful to be dissolved in a glassful of hot water and used as a gargle morning and evening.—N. Y. Medical Journal.

—o—

**Salol as a Bowel Antiseptic** is best prescribed, according to the *Journal of the American Medical Association* for July 25, 1908, as follows:

I.

R̄ Phenyl salicylate,	.....	℥ ss;
Bismuth subnitrate,	.....	℥ i.

M. et fac chartulas, 4.

Sig.: One powder every three hours.

II.

R̄ Phenyl salicylate,	.....	gr. xlv;
Bismuth subnitrate,	.....	℥ iiss.

M. et fac chartulas, 10.

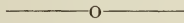
Sig.: One powder every two hours.

—o—

**Bloodless Operation for Internal Hemorrhoids.**—Dr. L. J. Hirschmann, Detroit, described his technic as follows: A hypodermic dose of morphin is given twenty minutes before operation, the bowel is washed out with a suds enema and boric acid irrigation; the patient assumes the Sims lateral position, the parts are shaved and cleansed, and then anesthetized locally by hypodermic injection of from 20 to 60 minims of beta-eucain lactate solution, previously sterilized by boiling strength from 0.1 to 0.5 per cent. The sphincter is dilated to whatever extent is necessary (usually not much), the hemorrhoids exposed and individually anesthetized; a ligature carrier armed with No. 2 catgut is passed through the mucous membrane at the base of the pile and so directed as to half encircle the pedicle submucously and emerge at the opposite side; the ligature is tied snugly, thus effecting a ligation of the whole

blood supply and only one-half of the mucous membrane. An analgesic suppository is given and the patient put to bed. Pain may persist for twenty-four hours, due to swelling. Inside of four weeks the piles thus ligated shrink and disappear, or the "nub" can be cut away. If there is no indication for haste, the pile can be removed at time of operation, leaving the wound to heal by granulation. He claimed that the procedure is recommended by its simplicity, brevity, safety and lack of hemorrhage.—Journal A. M. A.

Abstract of article read before Michigan State Medical Society, June 24, 1908.



**Resuscitation After Drowning.**—Superior, Neb., Aug. 6, 1908.

To the Editor:—I would like to see a discussion of the following points:

1. What is the longest authentic time that a body has lain under water and been resuscitated after removal?
2. If, on recovering a body from the water there is no heart beat perceptible to auscultation, will treatment avail anything, and if it should, is it not positive proof that the heart had not stopped?
3. How long should efforts at resuscitation be continued in hopeful cases?

J. G. WALKER.

Answer.—The effect of immersion in water depends on whether the person remains conscious and attempts to breathe or whether syncope occurs and breathing stops. If the first case death occurs in 1 to 5 minutes after water has entered the lungs. The power to remain under water without breathing varies considerably and is somewhat improved by practice. According to Draper ("Legal Medicine"), the longest time on record is that of Professor Enochs, namely, 4 minutes 46½ seconds. Draper also cites a report to the United States Life Saving Service of the resuscitation of Stanley S. Holmes, 5½ years old, after an immersion of 25 minutes. The resuscitation produced signs of life at the end of 45 minutes. Draper states that this is the longest time on record. In this case it is probable that syncope occurred and respiration ceased so that no water entered the lungs.

2. If in a case of drowning the heart has actually stopped beating, it is safe to say that the patient is dead and beyond resuscitation, but it must be remembered that the heart beat may be so feeble and indistinct as to be imperceptible even to the most expert

auscultator. Hence, one is liable to think that the person is actually dead when such is not the case.

3. From the above it will be seen that apparently hopeless cases may be hopeful ones, therefore efforts of resuscitation after drowning should be persevered in for several hours unless signs of death are positive. Cases are on record in which persons have been restored only after efforts had been continued for over four hours.—Journal A. M. A.

—o—

**Inhalation for Whooping Cough.**—The following is recommended to be added, a tablespoonful at a time, to a bowlful of boiling water, kept in proximity to the patient:

℞ Naphthalene, ..... 3ix;  
 Camphor, ..... 3i;  
 Oil of eucalyptus,  
 Oil of pine needle, ..... aa q. s.

M.

(It is to be presumed that enough of the oils are taken to effect dissolution of the naphthalene and camphor.)—N. Y. Medical Journal.

—o—

**For Hemorrhoids.**—

℞

Extracti belladonnæ fol. ....  
 Extracti opii ..... aa, gr. xv  
 Antipyrinæ ..... gr. xlv  
 Cerati plumbi subacetatis ..... 3iiss  
 Unguenti ..... 3i

M. et Sig.: Use externally as directed.—New York Medical Journal.

—o—

**Antiseptic Gargle and Mouth Wash.**—Robin (Gazette medicale de Paris, Sept. 5, 1907) advises the use of the following solution in the mouth and throat if there are enlarged glands in the neck:

℞ Betanaphtholis, ..... gr. iss;  
 Sodii boratis, ..... 3iiss;  
 Aquæ menthæ piperitæ, ..... Oi.

M. et Sig.: To be used warmed three or four times a day, to cleanse the mouth and throat.—Journal A. M. A.

—o—

When treating a case of albuminuria of pregnancy it is advisable to make an examination of the eye ground with the ophthalmoscope often, to determine if there is a retinitis present. If so

and it reaches a serious stage it is advisable (other conditions being equal) to immediately induce labor after which the albuminuric retinitis will subside. There is but one way to cure this disease and that is to promptly empty the uterus.

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**WHEN INTUBATING** never leave the thread in the tube after insertion. After the child has a few breaths and you are satisfied the tube is in place, the thread should be taken out. If cut short and left it forms a centre for the collection of secretion and consequent stoppage. If left long and fastened outside, the child may willfully or accidentally pull the tube out. One should not use an intubation set unless he can extract as easily as insert the tube.

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**Vaginal Anus.**—H. J. Whitacre, Cincinnati (Journal A. M. A., August 22), reports three cases in which there was a partial failure of development of the fetal septum dividing the cloaca into a posterior rectal and anterior urogenital portion. The anus with its sphincter was inserted into the vagina. On two of the patients, aged 8 months and 5 years, respectively, he operated successfully by transplanting the anus, sphincter and all, to its proper place. The important features of this operation and technic are, as given by him: First, an appreciation of the fact that, in his cases, the vaginal opening was apparently the end of the bowel. Second, that it was supplied with a sphincteric muscle that was entirely efficient in its new location. Third, preservation of the vaginal opening by a circular incision around it. Fourth, a dissection of the rectum, enabling the bowel opening to be displaced to about the normal position of the anus, carried out in such a way as not to interfere seriously with the nutrition of the rectum. Fifth, closing the perineum and vagina in front by sutures, exactly as in an ordinary perineorrhaphy, and, sixth, managing the bowels as in that operation.

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## NEWS NOTES

The annual meeting of the Mississippi Valley Medical Association will be held in Louisville, October 13th, 14th and 15th.

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The annual meeting of the American Academy of Ophthalmology and Oto-Laryngology was held at Cleveland, Ohio, August 27-28-29.



Dr. N. B. Richards, one of the oldest practicing physicians in Kansas, died recently at his home in Kansas City.

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Dr. J. E. Sawtell spent two weeks of September hunting in South Dakota.

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Dr. C. M. Stemen and wife spent August and September in Alaska hunting.

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The Northeast Kansas Medical Society will hold its next meeting at Atchison, October 8, 1908.

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Dr. F. M. Tracy, of Kansas City, a member of our society, received the Republican nomination for State Representative.

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Dr. Chas. S. Huffman, of Columbus, secretary of our society, was re-nominated on the Republican ticket for State Senator at the recent primary election.

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The Wyandotte County Medical Society will commence its next session Monday evening, October 5th. Meetings are held every Monday until June 1st.

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The Cherokee County Society held one of the best meetings in its history at the residence of Dr. E. L. Parmenter, in East Mineral on Tuesday evening, July 14th.

Dr. H. H. Brookhart, of Scammon, read an excellent paper on gall stones which elicited a lively discussion. He also presented a clinical case of empyema.

At the conclusion of the program Dr. and Mrs. Parmenter entertained us royally with a luncheon and vaudeville entertainment of vocal and instrumental piano music, string orchestra, colored buck and wing dancer, etc.

Owing to the heat the meeting was held on the lawn and at the conclusion all voted it the most enjoyable session ever held.

R. CLAUDE LOWDERMILK, Secy.

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The Wilson County Medical Society met at Fredonia, Tuesday, August 11th, this being the date of our regular meeting. Although we should have meetings every two months, this is the first quorum we have had since February.

Of the 25 physicians in the county, 20 belong to the County

Society, and of these, 10 were present. One Eclectic belongs to our society and he is one of our faithful members.

Two or three years ago we had some difficulty in our County Society about newspaper advertising. I took a decided stand against it, writing an article and citing some irregularities, but never once blaming any physician. In replying to my article some six months later, a member vented some of his spleen against me, which I did not consider worth answering. By common consent the members of our County Society have let the matter drop until recently. Certain reputable and competent physicians were receiving what was considered too much advertising in the local press, and the matter was talked over in a friendly way before the society, and as a result the following resolution was adopted:

"TO THE EDITORS OF WILSON COUNTY:—The Wilson County Medical Society at its regular meeting in August adopted the following resolution: 'In view of the fact that quacks and charlatans use the newspapers for the purpose of bringing their names before the public and whereas the regular profession has and does frown on this sort of thing for doctors, the Wilson County Medical Society hereby respectfully requests the editors of all newspapers printed in Wilson county to refrain from mentioning the names of physicians in connection with medical or surgical cases. Such mention will hereafter be considered a discourtesy to the physician whose name is mentioned. The Wilson County Medical Society takes this opportunity to extend its good will to the editors.'"

(Signed.) E. C. DUNCAN, Sec'y., 8-11-'08."

Program Rice County Medical Society, Sept. 17, Sterling, Kans.

Paper . . . . . Dr. P. P. Truehart

Ear Diseases . . . . . Dr. A. N. Gray

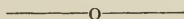
What a Nurse Should Know . . Miss Laura Kennan

Oct. 15, Lyons, Kans.

Electricity in the Treatment of Disease, Dr. J. H. Powers

Myocarditis . . . . . Dr. Theo. Kroesch

The Physician's Duty to the Public . Dr. E. C. Fisher



The S. E. District, Kansas Medical Society, will meet at Independence, Kas., Tuesday, October 13th. A good program has been secured, and a large attendance is desired. \*

L. D. JOHNSON, Sec'y.

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**References By Permission :**

T. D. Crothers, M. D., Hartford, Conn.; William J. Morton, New York City; Graeme H. Hammond, M. D., New York City; Frederick Peterson, M. D.; New York City; William L. Leszynsky, M. D., New York City.

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# THE JOURNAL OF THE Kansas Medical Society.

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Vol. XIII.

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No. 10

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## LOCAL ANAESTHESIA.

MERVIN T. SUDLER, M. D., Ph. D.,

Dean of the Scientific Department of the Medical School of the University of Kansas.

Read Before the Kansas Medical Society, May 8, 1908.

All of us who have had occasion to use an anaesthetic of any kind realize that the perfect anaesthetic has not yet been discovered. We do know, however, that our knowledge of their use is increasing and that many improvements have been added in the last few years. For instance, the present method of giving ether by the drop method is certainly an advance. Spinal anaesthesia has been tried and is apparently rapidly assuming a place where it will be recognized as a relatively safe and efficient way of removing pain in certain kinds of operations.

Local anaesthesia had its beginning when cocaine was first discovered, and as you all know synthetic compounds have been produced from time to time all of which are claimed by the manufacturer to be superior to any other yet known. The methods of using these compounds have also undergone striking changes. In the early days a strong solution of cocaine, usually four percent, was applied to a mucous membrane and local anaesthesia was obtained in this way. Later the hypodermic syringe was used and it enabled us to dull the sensation of a larger area. But if over a half grain of cocaine is used, disagreeable symptoms occasionally ensue.

We know that the sensation of pain in any superficial part of the body is dependent on nerve cells relatively distant. And that if by use of chemical or physical means we can block or prevent a nerve fiber from carrying the impulse that pain is not produced. If we inject enough physiological salt solution or even sterile water in the tissues around a nerve filament we produce enough disturbance of some sort in that fiber so that it is blocked and impulses do



not pass, even though there is no chemical reagent present to act directly upon it. Gant of New York has made use of this principle in operations on the rectum, and uses only sterile water. Apparently in this region of the body with a great deal of connective tissue this form of anaesthesia is unusually successful. Sleich made use of it and his formula has been successfully used for over ten years. That from these examples, the principle of using local anaesthesia for relatively large areas lies in the fact that we surround every nerve filament with a solution containing a sufficient amount of the reagent to block it. And in the case of cocaine and most of its substitutes this is very much smaller than was originally thought. For instance, a large amount of cocaine solution containing only one tenth of one percent will anesthetize a much larger area satisfactorily than will the same amount of cocaine if introduced in a more concentrated form. About 1897 Matas of New Orleans published an article in which he called attention to the use of a dilute solution of beta-cocaine. This solution was composed of physiological salt solution containing one fifth of one percent of beta-eucaine and one part to 100,000 of adrenalin chloride. This solution was absolutely non-toxic in any ordinary amount. First because beta-eucaine is only about one fifth as poisonous as ordinary cocaine, second because adrenalin chloride prolonged its action and caused it to be absorbed slowly. It has a further advantage in that the solution can be boiled with the exception of the adrenalin chloride. It has a disadvantage that its action is slower than that of cocaine. This formula has been used by Tinker of the Cornell Medical School for hernia operations, for tubercular glands in the neck, and by combining it with a one percent solution to block nerve trunks as they were isolated for prostatectomy in several instances. Mr. Barker, Professor of Surgery in the University college of the hospital Medical School, in a recent article reports the use of this solution in 22 cases of goitre. And he has used as much as seven ounces of the solution without causing any ill effects, and he reports that in his cases that the pain was satisfactorily done away with and that an assistant of Kocher who was present said that the anaesthesia produced by this solution was very much more satisfactory than obtained in Kocher's clinic where a small quantity of cocaine solution alone was used. For introducing this solution into the fascial planes in the vicinity of important blood vessels and other important structures he uses a round pointed needle with an eye on one side. He also says that it requires from thirty to forty minutes to obtain the full anesthetic

action of the solution, and it is his custom to infiltrate the skin and puncture it in various places and then introduce the solution into the lower part of the structures to be operated on by means of this blunt needle. I have not found it necessary to wait so long a time. I have found this special needle and syringes which I had made from his description to be of great service however.

In using this solution I have found the success depended upon making it carefully and making it fresh for each operation. Then infiltrate massively. Using from one to two ounces well distributed through the skin and tissues under it. After this is done cutting, pinching and a certain amount of blunt dissection causes no pain whatever. If traction is used or tension is put on tissue outside of the infiltrated area then pain results. So this method is not practical for operations where great retraction is necessary. As for instance an appendectomy, although cocaine has been used by Mitchell for operating on typhoid perforations. The class of operations for which it seems to be best adapted are those for the radical cure of inguinal and femoral hernia, varicocoele, hydrococcoele and phimosis. It is in regard to its use in the Bassini operation or its modifications for hernia that I wish especially to speak to you today: When we consider the extreme prevalence of congenital defects of the inguinal canal and the fact that most of these individuals are doomed to wear a truss or mechanical support of some kind to say nothing of the danger of strangulation and other injury, any improvement or simplification of the radical cure of these patients is eminently desirable. Various men over the country are using this solution or similar ones for this operation more and more. For instance, in a recent personal communication from Dr. James F. Mitchell of Washington he states that "I am still using cocaine (one tenth of one percent) for my hernia operations with increasing success, in fact I have not given ether for hernia operations for the past three or four years." And by the use of local anaesthesia I am sure that we cannot only perform the operation painlessly but so reduce the danger that it should be considered as a minor operation. The method which I have used and which has been successful in every case even in very nervous patients who were promised they could have the general anaesthesia at any time during the operation if they wished it, has been as follows:

Preparation of the solution:

Scherings beta-eucaine carefully weighed out and five grains put into capsules. This avoids weighing each time the solution is

to be made. Now bring six ounces of normal salt solution to a boil in a graduated porcelian vessel and add a few centimeters of distilled water and then boil until just the six ounces of salt solution is left. The five grains of beta-eucaine are now added and the heat turned out from the porcelian vessel. The solution is now poured into a Erlemeyer flask which has been previously sterilized. Just before using the solution 16 drops of a one to one thousand sterile solution of adrenalin chloride is added with a sterile pipette.

The patient is prepared as for an operation the same as under any other anesthetic, except that a screen is placed so the patient cannot see what is done. If the patient is at all nervous a hypodermic injection containing from one sixth to one fourth of a grain of morphine is given fifteen to twenty minutes before the operation is started. Beginning with a small hypodermic syringe and the finest and sharpest needle that can be obtained the skin is carefully infiltrated and the patient will feel the prick of the needle only the first time it is introduced. After this is done a larger syringe and a larger needle is used and subcutaneous tissues are then thoroughly infiltrated by using about one ounce of the solution. By the time this is done, the incision can be made and the external ring exposed. The blunt needle is then introduced into the ring and more solution inserted. The fine sharp needle is also used and the muscles and surrounding tissues carefully infiltrated. The sac and cord are then exposed and the inguinal nerve is found lying below and outwards from it or on it. This can be either held out of the way or else blocked with a fine needle and the operation continued. The only other point left to be infiltrated is at the internal ring where the cord and membranes should be carefully dealt with as their nerve supply is separate. When the sac is pulled up for final ligation the patient may complain of the tension for a moment, but that will be all. The incision can now be sutured without any pain whatever and the patient put back to bed and be given a light meal. There may be a little nausea usually about one in four, but they rarely vomit. The patients are kept in bed for from ten to sixteen days and allowed to leave the hospital with a tight bandage. They wear this bandage for two weeks longer and are cautioned against violent exercise of any kind for three months and then are considered cured. I have never seen anything but primary union after using this anesthetic. The healing is not delayed in any way.

As regards the method of operating one should cut and dissect carefully rather than pull and tear and the operations are usually done much more carefully and accurately under this than general

anesthesia. For hernia operation it takes from one and one half to two and one half ounces of the solution and it has required in my experience, from an hour and fifteen minutes to one hour and forty five minutes, whereas under general anesthesia it can easily be done in from twenty to thirty minutes. I have found the same proportions exist in other operations. The patients who have had this operation have been invariably pleased. Those that were most pleased were the ones who had taken a general anesthetic before. I am sufficiently convinced of its efficiency and desirability to the extent that I advise it in all uncomplicated cases and would certainly allow nothing else to be used on myself if I required an operation of this kind. It is not advisable where the testicle is undescended or the hernia of very large size.

In regard to the success of Bassini operations Coley has had nine relapses in 1,851 cases. Three of these in children were cured by a truss worn a short time leaving only six actual relapses, or five tenths of one percent. When we consider that if a person is willing to take two weeks in bed and the same care that they ordinarily take when a hernia is present for three months and undergo an operation which is not disagreeable in any way and the mortality of which is nothing as far as I can discover (in general anesthesia it is only one fourth of one percent) and be able to do without a truss or the danger of strangulation we cannot advise anything else than the radical operation. I believe that the practitioner who fits trusses or advises them in individuals suffering from hernia over four years of age is not doing the wise thing for his patient.

And for the patient himself the danger of dying from strangulation is supposed to be somewhat greater than one fourth of one percent. So in addition to the discomfort of wearing a truss he is in greater danger of losing his life with it, than he is as a result of the operation. In regard to using this solution for other purposes I have used it for the hydrocoele operation and in varicocoele. For these operations the blunt needle is of greatest service, and as I have mentioned before the cord derives its nerve supply from a separate source and it must be thoroughly infiltrated at its highest point if its manipulation is not to cause distress. In operations on glands of the neck of which I have done three recently in patients where general anesthesia seemed inadvisable I found it possible to excise them thoroughly though here there was always pain on traction when the deeper portions were removed, though not unbearable in any case. And the patient's condition was so much better afterwards than it would have been without it and I shall continue to use it in selected cases of this kind.



In exophthalmic goitre and in ordinary cystic goitre it certainly reduces the danger of the operation to the minimum and Keen's recent system of Surgery advises general anaesthesia only when it is impossible to use this. In any of these operations a syringe holding at least ten cubic centimeters and the blunt needles are absolutely necessary for success.

The anesthesia lasts about two hours. If the adrenalin is good and fresh, as it should be, and the area infiltrated is unusually large then it may last as much as three hours. However, no operation should be undertaken which goes much over one hour and a half, as the patient gets tired and may become nervous from lying in one position a longer time than that, even though the table has been made comfortable by pillows and other appliances of that sort.

In circumcision I have used the one tenth of one percent solution of cocaine as it acts quicker and is a little more convenient to use on account of that and enough to cause toxic symptoms is never used. The average amount injected is only about one eighth of a grain, and Dr. Mitchell uses the same solution for his hernia operations as I have just quoted to you.

I do not claim that in these solutions we have a perfect anesthetic; neither do I claim we have one which will do away with ether, chloroform or other anesthetics. But I do claim that by this method we can do certain operations with safety where a general anesthetic would be dangerous, and often without pain or very slight pain, that we can do hernia operations, hydrocele and varicocele and phimosis operations without pain and with a minimum amount of discomfort to the patient and a maximum amount of recovery in view for him. Like every other surgical method the more one uses it, the more skill is acquired and the happier the results. It is a method where utmost care must be taken at every point, and I would not recommend it to anyone who is slipshod or careless in his technique. On the whole it is harder to use than to operate under a general anesthetic, for it takes longer, and takes more care. Ordinarily I am much more fatigued from an operation of this sort than from the other. But where an expert anesthetist cannot be had and in the class of operations I have outlined I believe that it will prove of great service to the medical profession. And if it comes to be generally known and used, I believe we will reduce the business of the truss manufacture to a very small percentage of what it is at present.

#### DISCUSSION.

Dr. Andrews, of Batlimore.—That is an extremely important paper, and a plan that is attracting a great deal of attention in New York City.

This winter I attended a course in New York, and Dr. J. A. Bodine used it extensively. Dr. Wyatt has a slight modification of it, the same method but he uses a different chemical. You are all familiar with the salt known as urea-hydrochloride, used in malaria where the paroxysm was very great. Dr. Wyatt in his lecture said he went down to his old native home on White River, and went out with a young country doctor to see a case of local anaesthesia operation, and the doctor surprised him by using quinine and urea-hydrochloride. He had made this discovery in the use of the drug as an antiperiodic.

One point I rose to mention is in regard to the capsule containing the cocaine; I think the doctor will say he has had difficulty in getting what he wants. Dr. Bodine uses 1-5 of 1% instead of 1-10 of 1% solution, but he advises a capsule made of glass. A homeopathic tube is drawn out to two points, it is pushed together in the heat and resiliency formed by pushing together the glass, but first that is brought between the two thumbs and fore fingers and snaps readily; it contains the proper amount of urea-hydrochloride and the proper amount of salt, and the addition of the two in solution gives a perfectly aseptic solution and is a great convenience to the physician who cannot get to the pharmacist. Dr. Wyatt also has adopted it and uses his combination in the same sort of a tube. He uses four times the strength Dr. Bodine uses

Dr. J. S. Wever, of Kansas City.—I do not propose to discuss hernia operations. I propose only to mention the use of cocaine in tonsillar operations such as I have done for about six months. The plan I used is not original with me. Some man published it in the Journal of the American Medical Association, and his plan probably grew out of some method of the old infiltration method, the combination of weak solution of cocaine, morphine and salt solution. In removing the tonsils, I do it with a cautery point, to emphasize the fact, that would be painful if anything would. The solution I make up is measured. A dram and a half of the solution is measured out and quarter grain tablet of cocaine is dropped into that, and anywhere from 3 to four or five drops of the ordinary 1 to 1000 bichloride solution is put in it. The instrument I use to inject into the tonsil is called the Universal Syringe. The throat is swabbed particularly over the point where you are going to make the first puncture with the 10% solution of cocaine and when the infiltration method is used from then on; used just as it would be anywhere else in the body. The claim has been made in the use of that solution there is a good deal more sloughing forms than in any other form of operation, but I don't believe that happens, and the results Dr. Sudler and the other authorities he quotes had would bear me out in that statement. The sloughing that comes soon after use of it is not a fact. The solution as used gives an absolutely painless method, even where as painful a method as a red hot point is used in dissecting a tonsil from its base rather the scissors or the knife.

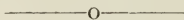
Dr. J. G. Sheldon, of Kansas City.—This question of local anaesthesia Every few years there is an epidemic in the use of this method. In 1900 a few articles appeared. For instance, men like Ferguson Smith used it in quite a number of cases and got good results, and most all of them that work in the infiltration method, all act practically the same. As a rule it works very well indeed but for some reasons there are exceptions to the rule, any one who operates in a large number of cases will find these exceptions. In the division of blood vessels this method does not produce anaesthesia in all cases. That has been shown very distinctly, and in these cases there has been pain at the division of nerves, slight sometimes but depending on the character of the patient. The method is a very good one for selective cases but I don't believe the majority of operators will use it for all of their cases. It seems to me when we consider the question of shock, that is an important consideration.

There is another thing that must be considered if one will do all sorts of hernias there are certain accidents. Occasionally the bladder will become adherent. Every once in a while a chronic appendicitis exists with the hernia. It is a very good thing to operate for this with it. A

great many people who gave this a trial in 1905 could use it only as an exception and not as a rule.

Another thing is infection. In old people there is danger of infection getting through the blood of the patient, especially if the hernia has been done, and there is strangulation. Regardless of the technique of the operation, this condition of the patient's infection must be considered, as this occurs every once in a while when the tissues have not been infiltrated; this is probably more apt to occur in cases where we have the smaller tissues filled up with the fluid and which interferes with the circulation. That has been considered for a long time. It may not make any particular difference. Personally, it seems to me that while the healing is good, occasionally where an infiltration has been done, there seems to be more swelling after the operation.

Dr. Sudler, (closing the discussion).—About these methods I think Dr. Wever is quite right, or at least my experience has been similar to his, that the pain has been absolutely prevented. I know local anaesthesia is becoming more widely used all the time. In regard to Dr. Sheldon's objections to the use of the anaesthesia in certain cases, there are certainly cases where his objections hold. In my closing paragraph I believe I said I did not claim it was an ideal anaesthetic by any means, but I do claim that hernia operations you could do just as I said, and there are a great number of men all over the country using it. (Matas, Tinsler, Mitchell, Cushing, and others.) This method is not the kind that will appeal to the lazy operator. It is certainly a great deal more trouble. I expect people who have given it up have done so on account of the time and trouble it took, rather than on account of any actual deficiency they found in the method, because all the men I have talked to who have used this method, their praise has been unqualified. My experience has been great enough to convince me it is a very proper method and a very desirable one, and one that has a rather wide range of usefulness.



## BACTERIOLOGY AND PATHOLOGY OF ACUTE RHEUMATISM.

DR. C. C. NESSELRODE, Kansas City, Kansas.

Read Before the Kansas Medical Society, May 8, 1908.

Acute Rheumatism takes a very important place among the diseases of temperate climate, and has from ancient times attracted much attention. No disease is more difficult to define and of the more common diseases none has been more complicated by theories.

We read in the earlier writings of a rheum or catarrh which flowed from the brain into the various regions of the body and caused great pain where ever it found lodgement. This vague and indefinite theory has survived even to this day in a modified form and many times we hear a vague ache or pain called, for lack of an accurate diagnosis, rheumatic.

Cullen attributed rheumatism to the direct action of cold upon the joints and held it to be essentially a local inflammation followed by a general fever.

This theory was followed shortly by the one advanced by J. K. Mitchell according to which exposure and chill caused an irritation of the cutaneous sensory nerve fibers over a wide area and thus to set up a central disturbance in the spinal cord and medulla. This disturbance was transmitted to the nerves of the various organs and tissues which were implicated by acute rheumatism and caused in turn the various manifestations. This theory marked an advance in the true conception of the disease in as much as it was the beginning of the tendency to recognize rheumatism as a systemic and not a local disease.

The chemical theories were next in order and opened up new paths for investigation although none of them could claim to be satisfactory. The two most widely urged and most generally accepted were: the one ascribing the cause to an excess of lactic acid, and the other to an excess of uric acid. Richardson and Ranch were perhaps the most enthusiastic advocates of the lactic acid theory and went so far as to report some cases of polyarthritis, endocarditis, pericarditis, etc. produced by the injection into the peritoneal cavity of dogs of a 10% sol. of lactic acid but other and later workers failed to confirm their observations.

And so gradually the theories one by one fell into disrepute because of a lack of proof.

Perhaps no one thing has stood more in the way of a correct conception of Rheumatism than the tenacity with which most of the writers have held to the contention that rheumatism was an arthritis, a local instead of a general disease. That endocarditis, pericarditis, etc. were complications instead of a part of the picture. But the gradual tendency has been for a century to recognize it a disease with numerous manifestations. The first step in this direction was in 1827 when Scudamore first reported a number of cases of endocarditis and pericarditis arising from rheumatism and 10 years later Bouilland was so impressed by the frequency of cardiac lesions that he grouped them as true rheumatic manifestations, a part of the picture. Then in 1850 Batrel held all chorea to be rheumatic and in 1868 Hiller described the rheumatic nodule, and 1888 Cheadle in his Harveian lectures conclusively demonstrated the widespread lesions of the disease. The natural consequence of these observations was the involvement of the theory of the infectious origin of rheumatism and the dropping from its name of the word articular. This theory is supported by the most convincing evidence. To quote Dr. Cheadle's words, "The occasional epidemic prevalence, the variability of type, the incident upon the young, the occurrence of tonsillitis,



of endocarditis, of pneumonia, of erythematous eruptions; the rapid anemia, the tendency to capillary hemorrhage and albuminuria; the implication of joints, the relapses, the occasional super-vention of hyperpyrexia, the nervous disturbances, the specific power of salicylic acid are all suggestions of an infectious disease." The pathological and bacteriological findings in support of this view are most convincing.

Although it is now generally accepted by the best authorities that acute rheumatism is a systemic infectious disease there is no general agreement that it has but one exciting cause. On the other hand there are many who maintain that different infective agents of the micrococcal group may produce acute rheumatism. At present there are about four views held as follows:

1. That there is no specific micro organs but that the disease is a form of pyemia due to an infection with an attenuated staphylo or streptococci.
2. That it is due to a specific bacillus.
3. That it has a specific organism—a diplococcus.
4. That it is infectious but that its specific cause is unknown.

As the second one can be disposed of the quickest I considered first. In 1891 some French observers claimed to have isolated a bacillus from several cases dead of acute rheumatism. Other observers have failed to confirm their work and as the organism described by them was about the size of an anthrax bacillus it seems impossible to believe that if they were right that this organism could be continually overlooked by the other observer.

The first view, that rheumatism is an attenuated pyemia is one widely held yet it seems to me there are many and grave objections to this view.

First. acute rheumatism is a very common disease many times more so than pyemia.

Second. It isn't one case in a hundred that has the primary lesion as has the cases of pyemia. It is true enough that there is occasionally a case following a tonsillar abscess a mastoid abscess or some other infection that has joint complications but for one of these there are hundreds of cases of acute rheumatism arising in such a manner and pursuing such a course that they cannot be grouped as an attenuated pyemia without making a pure assumption without a parallel in the entire field of medicine.

Third. Acute rheumatism is not always an attenuated infection but is many times most profound and deadly. A patient completely prostrated, sweating profusely, temp. 104 or 5, pulse 140, two or more joints swollen and exquisitely tender a pericardi-

mem distended with fluid is hardly the victim of an attenuated infection.

The third view that the disease is produced by the diplococcus rheumaticus seems to be now quite well established as the observations of different men widely distributed over nearly the whole world have been on the whole remarkably constant. Among the pioneers should be mentioned Mantle, Klebs, Leyden, Loeffler, Westphal, Wasserman, Malkoff, Poynton, Payne, Meyer, Walker, Beattie, Loncope and many others. Tribouler in 1898 produced endocarditis in a rabbit by the injecting into it of a diplococcus he had obtained from the blood of a patient with rheumatic fever.

Westphall and Wasserman in 1899 produced multiple arthritis with fever in 80 rabbits with a similar organism obtained from a fatal case of acute rheumatism.

In 1900 Poynton and Payne, whose work has probably been the most thorough and extensive, reported their investigations in which they had isolated this diplococcus from eight successive cases of acute rheumatism, and had shown its presence in the most important human lesions, they had produced these various lesions in rabbits and then had isolated the diplococcus from the animal's tissues; since that date they have increased their number of cases from 8 to 35 at the latest report of which I know. To these men belongs most of the credit of the work with this organism but their work has been confirmed by almost innumerable number of other observers.

The chief characteristics of the organism are: It is a small micrococcus 5 micron in diameter and usually grows in pairs or short chains. As a rule it does not show a capsule, stains readily with analine dyes, it retains Grams stain, but not with very great tenacity degenerative forms are common and then the micrococcus appears swollen or pear shaped.

Cultural Characteristics. It grows upon most any media. Perhaps best upon blood agar or a mixture of bullion and milk acidified by lactic acid. Does not liquify gelatin.

It has a remarkable vitality. It is interesting to note that Poynton and Paynes' original organism is still growing in sub-cultures.

Blue litmus milk is turned pink in 24 hours so the organism is an acid producer, which might account for the early acid theory as to the origin of rheumatism.

The fourth view that the cause is unknown is due mostly to the work of Cole of Baltimore who has produced endocarditis and

arthritis in rabbits with a streptococcus obtained from a source which was not rheumatic.

His lesions he claims are identical to those produced by the micrococcus of rheumatism.

But the work of Poynton and Payne must not be lost sight of in which they isolated the same organism from 35 different cases. Reproduces the same lesions in animals and recovered the same organisms from these lesions.

In discussing the strict pathology of acute rheumatism a few general propositions are at first necessary. First. Acute rheumatism is essentially a bacteriemia. Its lesions are produced by the lodgement of these bacteria in the end capillaries of any of the tissues of the body.

Second. The character or severity of the lesion depends upon either of two factors, the virulence of the infection, or the resistance of the individual.

Third. It is usually the serous surfaces, such as the articular surfaces the endocardium, pericardium or the pleura, that are involved yet the infection comes from the circulatory side, the back as it were, and that the lesion is first subendothelial.

Fourth. That microscopically the early lesions are the same whether it be beneath the articular endothelium or the endothelium of the heart or pleura.

The pathological changes are for the most part easily understood. The exact changes produced by the toxins cannot, it is true be demonstrated, but the macroscopic and microscopic appearances are quite easy to be explained. It is of the uppermost importance to bear in mind that these lesions, the carditis, arthritis nodule formation, pleurisy etc., are primarily due to the local deposition of the bacteria in these situations and not the results of toxins alone. The bacterial infection in rheumatism is widespread and not localized as in diphtheria.

From this infection of the various tissues three types of lesions result:

First. The simple type. Second. The fibroid. Third. The malignant.

First. In the simple, which is nicely illustrated by acute rheumatic arthritis, the bacteria are rapidly destroyed by the resistance of the tissue and the inflammation quickly subsides.

If the infection is more severe or the resistance impaired, death of some part of the effected tissue will occur and with resolution this dead tissue is replaced by scar formation. The thick-

ening of the mitral valve in simple acute endocarditis will illustrate this form of repair.

The microscopic changes are dilatation and sometimes rupture of the blood capillaries with well marked swelling of the connective tissue, in their neighborhood. Where the process is most severe the connective tissues pass from the stage of cloudy swelling to that of necrosis and the area is invaded with leucocytes.

With resolution fibro-blasts invade the necrotic area and thus a scar is formed.

When these changes occur in sub-endothelial tissues of a serous membrane such as the synovial, pericardial, or pleural there is a rapid exudation into the serous cavity of a clear or but slightly blood stained fluid which later becomes sero-fibrinous. It is often said that suppuration does not occur in acute rheumatism and this is true enough if the term suppuration is restricted to the yellow fluid formed in pyemic abscesses. In severe rheumatic pericarditis the condition is to all intents a rheumatic suppuration.

The relation of the bacteria to the exudation is interesting and easily understood; yet their absence from the early exudations has more than any other single fact influenced investigations against bacterial origin of acute rheumatism. These diplococci escaping from the minute blood vessels are necessarily at first located in the subendothelial tissue and the endothelium serves as a bar to their escape into the serous cavities. For this reason there is great difficulty in finding them in acute effusions. Later on when the infection is more severe the leucocytes overcome and ingest the bacteria. The condition in which they are easily found is a rare one when the infection is virulent or resistance weak.

Second. The fibroid type is best exemplified by the well known condition of mitral stenosis. It is a subacute inflammation of a persistent character which without producing any considerable amount of necrosis produces a gradual sclerosis. It is also met with in some cases of persistent subacute pericarditis and in those cases of rheumatic arthritis in which there is much swelling of the peri-articular tissue and run a protracted course.

There is no well marked line of demarcation between 1 and 2 but there is this practical value in recognizing them that it brings into prominence the difference in the prognosis of the lesions and emphasizes the persistent nature of the rheumatism in the fibroid type probably due to the lack of resistance.

Third. The malignant type is best exemplified by certain cases of rheumatic endocarditis in which the micro-organisms are not killed in the tissues but multiply in the damaged valve and



are then disseminated by the blood stream throughout the system. In the most severe form the vegetation on the valve are minute and yet there are immense numbers of bacteria in them; in those of less severity there are large fungating vegetations in which many bacteria may be present but in which many are destroyed.

The intimate changes produced by the rheumatic toxins are not well known but one condition is clearly recognized namely fatty degeneration. This is usually well marked in the cardiac muscle and also in the convoluted tubule of the kidney when they are severely attacked.

As to the distribution of the lesions in acute rheumatism it is almost the rule to look upon the joint symptoms as the essential ones and upon the carditis, the chorea, etc. as complications. But it seems to me to be more logical and more in keeping with the later teachings to look upon the latter, the carditis and chorea, as being as much essential part as the arthritis. In fact many times either of these may manifest itself before the arthritis is recognized. And there are a number of authentic cases recorded where the carditis or the chorea were the only symptoms present of an existing infection with the diplococcus rheumatism.

Church reports 889 cases of rheumatism in which 494 or 57.5% showed an endocarditis. In the 500 cases admitted to Bellevue Hospital in the last 3 years 253 or 56.6% had an endocarditis. Now if we add to these percentages the number of cases of myocarditis and pericarditis that occur without an endo-carditis we will see that heart involvement is almost as constant in acute rheumatism as is joint involvement.

In endo-carditis the infection of the valves occurs through the coronary arteries and the bacteria find lodgement in the subendothelial lymph spaces and here begins the resulting inflammation, identical with the process that goes on around the joints and tendon sheaths.

The myocardium is a tissue that is involved many more times than was formerly supposed, it is being more and more clearly recognized as the greatest danger in cardiac involvement in acute rheumatism.

Pathologically the changes in acute myocarditis seem to be acute parenchymatous degeneration of the muscles. This may be recovered from but when the process is protracted it can go on to fatty degeneration which may recover or may go on to brown atrophy or fibroid degeneration.

In the acute stages we see therefore a process which is especially prone to diminish the function and produce dilatation of the

muscle. In the chronic changes we have a process which prevents the vigorous hypertrophy necessary for the increased demands of compensation, and a muscle in which brown atrophy and fibroid degeneration are prone to develop and weaken its contractile powers. In the time allotted us we cannot go into the other manifestations of acute rheumatism except a word as to the rheumatism nodule, for its pathology may be slightly different from the typical lesion described. First there are deposited, along the tendon sheaths, in the muscle, or whenever it may be a number of bacteria and the process started much the same as in the other lesions but with more proliferation of the connective tissue elements and the production of a node much after the fashion of a tubercle. Now with the killing of the bacteria a degeneration change sets up in the node with usually a deposit in the degenerating tissue of lime salts and there is left a calcareous nodule. Some entirely reabsorb without this deposit of lime salts.

In closing we will draw the following conclusions.

First. Acute rheumatism is an infectious disease in all probability due to the *diplococcus rheumaticus*.

Second. That it is a systemic and not a local disease.

Third. That its lesions are histologically the same whether found about the joint, in the endocardium, pericardium, pleura, meninges or in the muscles with but the slight exception in the case of the rheumatic nodes.

Fourth. That the micro organism is one that has a peculiar property of involving, by choice, fibrous tissues particularly sub-endothelial tissue. And but very rarely involving parenchymatous structure such as the liver pancreas or kidneys.

Fifth. That the severity of the lesion and the rapidity of the course depends upon that very much talked of property of the individual—resistance.

#### DISCUSSION.

Dr. J. S. Weaver, of Kansas City.—The only suggestion I wish to give to the doctor's paper is taking up the pathological side of the question. He, so far as I was able to hear, has not taken up the point of infection. In a series of several thousand cases reported several years ago by Major Kiefer of the regular army, he came to the conclusion in a very large percentage of the cases, the infection took place through the tonsillar region, as at any rate there was a close connection between tonsillitis and rheumatism, as proven by these cases. In a series of one hundred cases reported by Fletcher Ingalls of Chicago, he said he had been rather against the idea that the tonsils had anything to do with infection in rheumatism, but from taking this series of one hundred cases, taken impartially from his records, he found 45% of these cases either had had acute articular rheumatism before or shortly after they had the tonsillitis. I don't believe the paper included treatment, so that is not under discussion.

Dr. C. C. Goddard of Leavenworth.—It was certainly a beautiful paper, well worthy of discussion, and although I have not made any study of it,

I had to come to the conclusion some time ago that rheumatism, so-called, was never a local trouble. We had a peculiar thing in the army a good many years ago when I was connected with it at Ft. Sill. We had a number of troops that had been there for three years and over. They started in with a great amount of malaria in these commands. Those same men the second year developed what they called rheumatism, or forms of rheumatism, and were discharged the next year, about 20 per cent for heart lesions, and it certainly was infection there, of some kind that produced this peculiar train of symptoms and disease. I was very much interested in the paper and very glad I heard it.

Dr. P. S. Mitchell, of Iowa.—My observation of rheumatism from is personal experience. The rheumatism following tonsillitis is not so virulent and not so persistent as in acute rheumatism starting from other causes. I observed rheumatism following tonsillitis very often will run a course of five or six days and go away and perhaps come on in a few days and go away again, while the rheumatism that lasts six or eight weeks and is very persistent, usually is not preceded by tonsillitis. That has been my experience and has caused me to wonder a little bit whether we have a different infection.

Dr. C. C. Nesslerode, of Kansas City, (Closing the discussion).—I don't know as there is anything more to be said, excepting as to the suggestion of Dr. Weaver, it was a very just criticism,—I really had overlooked that point until he called my attention to it. So far as I know I have nothing to add except along the very line he has spoken of, that the result of the observations of most men is to connect rheumatism in some way with tonsillitis, or to suppose, anyhow, that the source of infection is usually through the throat.



## A FIBROMA OF THE ABDOMINAL WALL.

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The following case is reported because it seems to present a tumor form sufficiently rare to be interesting. Attention has recently been called to tumors of the abdominal wall by an article in the August issue of the *Annals of Surgery* by Harvey B. Stone, entitled "Desmoid tumors of the abdominal wall." In this article Dr. Stone tries to differentiate desmoid tumors from those of like appearance and he defines the word as referring to "fibromata or fibro-sarcomata arising from the musculo-aponeurotic structures—muscles, muscle-sheaths, aponeuroses, lineae transversae, etc.—of the abdominal wall itself, thus excluding tumors originating in the bony pelvis or the round ligaments, as well as those springing from the skin or subcutaneous tissues."

Ours is a tumor springing from the subcutaneous tissues and we would call it a fibroma. Its interest lies largely in the fact that under the conditions one would naturally expect a keloid, or at least a sarcoma.

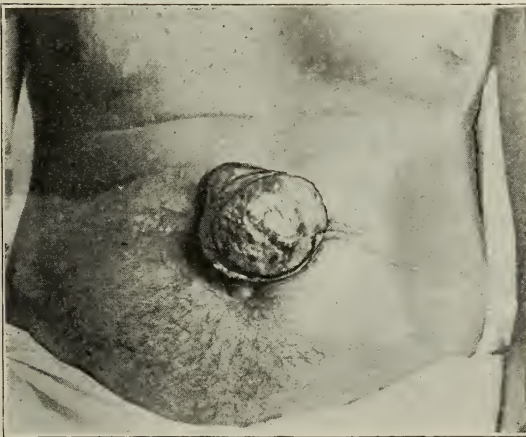
## Case History.

A. J.—Colored; Age, 42; Male; Porter; Weight, 175. Complaints of pain in abdomen, especially on lifting, and also of a tumor which bleeds intermittently and is painful most of the time.

Family history negative. Personal history shows that he has not used much alcohol, but that he smokes excessively. While a child, he was struck in the abdomen, which resulted in a bruise,



Side view of tumor in situ.

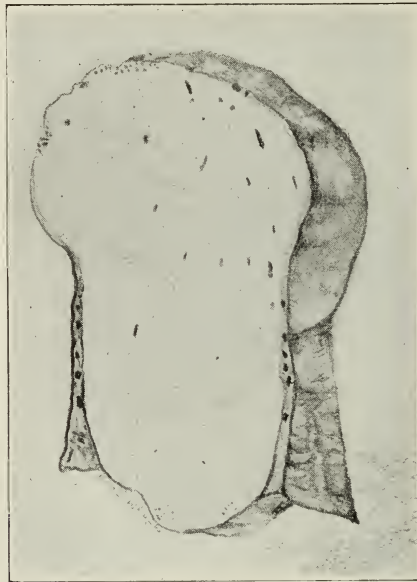


Front view of tumor.



and finally a tumor which was removed by Dr. Griffith, 20 years ago.

Temperature, 99.2 Fahrenheit. (This was July 16, 1908). Pulse, 116. Bowels reported as regular. Appetite good though the tongue was coated. The conjunctivae were injected. Over the epigastrium was a peduncleated tumor with a lateral diameter of  $4\frac{1}{2}$  centimeters; vertical, 6 Centimeters; circumference, 17.5; circumference of pedicle, 14. This appears to be on the site of a scar due to the excision of a similar tumor 20 years ago. Apparently, the tumor springs from the skin. Patient has also right inguinal hernia.



Gross appearance of tumor section.

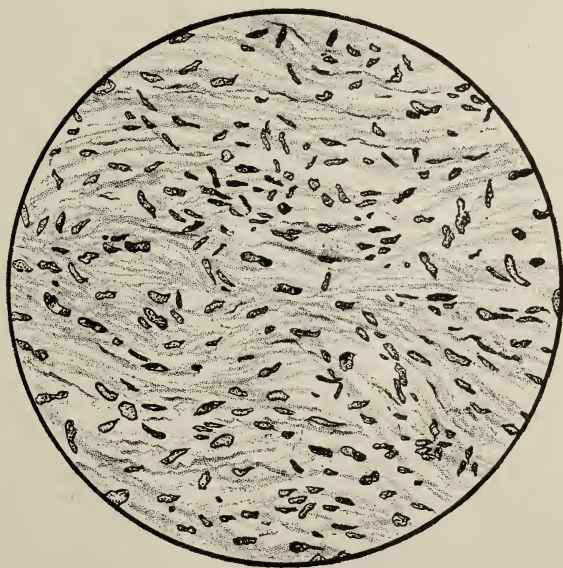
The tumor was removed under 1% cocaine; the epigastric veins were considerably dilated and caused some hemorrhage. The tumor was found to be beneath the skin, to be encapsulated, and to have no connection with the tissues below. It weighed, when fresh, 112 grams. On account of the removal of considerable skin, the wound closed by cicatrix.

#### Laboratory Findings.

Pathological Laboratory No. 1845. Description:—This specimen is a slightly pedunculated growth, the consistency of which is firm to pressure. The surface of the tumor, extending well

down to the neck, shows a superficial ulceration apparently involving the outer layers of the epidermis only. This ulcerated portion seems to be highly vascular, as capillary bleeding shows at numerous points. On making a central longitudinal section the tumor proves to be a pearly white color, homogenous and perfectly encapsulated by a very thin though tough capsule. This capsule seems to be well separated from the subepidermal tissue, strips from the tumor easily and at the base shows no intimate connection with the tissue beneath. At the periphery of the tumor are a number of small delicate walled blood vessels, some of which are filled with recent thrombi. The centre of the tumor shows no visible blood vessels.

Microscopical Section:—Section shows the capsule of the tumor to be quite independent of the subepithelial connective tissue but the cells of the capsule merge with those of the tumor, a slight separation only, being marked by a rather rich plexus of small blood vessels. The tumor is rich in cells, only the nuclei of which are visible, imbedded in a poorly fibrillated, finely granular matrix. The cell nuclei are elliptical or fusiform,—chromatin network poorly defined—fragmentation and degeneration nuclear forms being rather numerous. The blood vessels have a well defined endothelial lining surrounded by a rather broad band of



Microscopic appearance of tumor. Note the lack of chromatin in the nuclei.

non-nucleated tissue which fuses with the surrounding cellular stroma. Many of the vessels are completely filled with hyaline material, which is also true of some of the extra-capsular vessels, but here some of the larger hyaline thrombi show central channels filled with erythrocytes.

Diagnosis: Subcutaneous fibroma.



## SOCIOLOGICAL ASPECT OF GONORRHOEA.

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Read Before the Kansas Medical Society, Iola, Kansas, May 7, 1908.

The reading of a paper on this subject is a thankless task because even yet the subject is somewhat tabooed among medical men. Only 16 years ago, after Valentin had read a paper on venereal diseases before the A. M. A. in N. Y. one man said that this was a Christian country and the association a Christian Association and no such vile stuff should be allowed to come before the society. A few years later Howard Kelly stated that the subject is attended with filth and we besmirch ourselves by discussing it in public. Since that time he has himself written and published articles on this subject. Times have changed and we are now in a time of great moral uplift and the time is here when we as medical men should take hold of this problem which is second to none in importance.

Strange as it may seem the disease appears first associated with religious rites, a kind of enforced religious prostitution. It is noteworthy that the virgins of the sun in Peru did not lose their caste after being mustered out and that at certain periods women vied with each other who should consecrate themselves to the heathen Gods. The women consecrated to Baal and Moloch are examples. Jeremiah relates how such women sat around the temples and offered themselves to men and it is a matter of history that within a short stay of one month these women put hors de combat more of Alexander's army than all the men they had fought. Similar customs prevailed in Egypt in the worship of Isis and Osiris. According to historical record the Hebrews were the only ones to recognize the harmfulness of the disease and in numbers V:2 we find that those having a flow from the flesh were required to stay out side the camp until the discharge stopped and then 7 days longer.

As civilization grew, instead of recognizing these religious devotees they were regarded with scorn and their rights both

religious and civil were taken from them and they were regarded as outcasts. Solon introduced the law which legalized prostitution under the erroneous idea that it would protect respectable women from the results of infection an idea still shared by a few people. This law led to the licensing of prostitution with all the evil results that follow such police regulation. Conditions became so bad that Roman men would not marry and both Tacitus and Marttal write that there was not a virtuous girl in Rome in their time.

From Rome the conquered Teutons became contaminated—even Charlemagne the socalled Christian Emperor lived in polygamy and his clergy and courtiers were dissolute. When the Duke of Alba marched against the Netherlands he took 1200 prostitutes and the Crusaders of 1180 had 1500 with them, yet we are accustomed to think of the crusaders as a type in an age of chivalry. It was about this time that the Reformation began and syphilis appearing as a devastating plague helped it along and caused people to lead a cleaner life. But court life, on the whole, remained more or less immoral and when the 30 years war broke out followed by the 7 years war, conditions went back to the old level. The common brothels would be closed and opened alternately until finally in 1854 they were abolished as sources of national revenue although it seems that immorality always persisted and thrived in court life as it does today. It is said that even yet the custom prevails, in remote parts of Morocco of providing for the sexual entertainment of a guest even to the offering of the daughter, and the geisha girls of Japan serve the same purpose. The prevailing viewpoint on the continent at the present time considers prostitution an inevitable evil to be so guarded as to lessen its harmfulness as much as possible. In brief the history of the disease shows that beginning as a pious religious institution it gradually degenerated into the profane then into such vile depths of wickedness that the government fostering it fell. Since the Reformation conditions have been growing steadily better until now we are living in an age of the greatest morality than the world has ever known.

The gonococcus was discovered by Neisser in 1879. No toxic products have as yet been isolated possibly because of the difficulty of growing it in pure culture on artificial media. The organism is so susceptible to adverse conditions that it will die in a few hours when in a dry condition and even when on moist towels or soiled clothing it will live only a few days. It has never been found originally in any of the lower animals and only a few investigators have claimed to get it to grow in some of the



ape family. Strange that it should grow so readily and persist with such persistency in the human unless as a punishment for a sin that does not exist elsewhere.

No race is exempt although the Esquimaux were free from it until the last few years. Something of its prevalence may be inferred when it is stated on good authority that 75 % of the males of each generation have gonorrhea at some time in their lives, that from 50 to 60 % of all gynecologic work is gonococcic in origin, that 15 % of all the patients in the Paris Hospitals and 10 % of those in N. Y. are venereal while  $\frac{1}{3}$  of the outpatients of the London Hospitals suffer from the same cause. Conditions are not so bad in the U. S. as on the continent; still we have more than 10,000 in our blind asylums, not counting the partly blind, due to gonorrhea. It is stated that 90 % of the men infected marry before they are cured; if only 5 % of these infect their wives there are 800,000 innocent sufferers—more than the whole number of public prostitutes. 5,000,000 would probably not cover the whole number tainted with this disease in our own country. It is even more dangerous than syphilis because of its greater frequency and because it is considered of so little moment while in fact its results are just as bad and its cure much less certain. Moreover we know that childless marriages are becoming more and more frequent among native Americans especially and that most of them are not so from choice but that in  $\frac{3}{4}$  of them the husband is directly or indirectly responsible. I do not believe that marital infections occur from any lack of conscience—rather they occur because he is ignorant not only in its acquirement but in the knowledge of its long lasting and latent contagiousness.

The causes leading up to these conditions are easy to find and the above results are more definite than the statistics which are open to question and which will not hold in agricultural parts of the country. The primal causes of illicit intercourse are doubtless the innate tendency in the male toward polygamy and in the female toward polyandry. Many of the laity and a few of the profession believe that there is a sexual necessity in all men which if unsatisfied makes them less manly. But most of us will agree that the secretion has a natural outlet in physiological emissions and that no amount of disuse will cause atrophy—not even when the tubes are blocked by gonorrheal adhesions. As for impotence resulting from continence, I will venture the assertion that no one here has ever seen a case in a continent man and not one of you but has had cases resulting from immorality. Another cause for so much gonorrhea is the lightness with which it

is regarded not only by the average man but by many medical students and all too many doctors. The young fellow with his first dose often comes into the office with a swagger and thinks as little of the disease as he would of measles or whooping cough. And I have seen it stated that gleet was curable by getting married! Another factor is the great number of public and private prostitutes of whom the clandestine is by far the more dangerous, at least outside of the large cities; but the greatest source of contamination is the presence of so many diseased men free to infect whenever they have the inclination and the price.

It is vastly easier to point out the causes and the results of gonorrhea than it is to suggest worthy and effective means of cure. If we could only teach the young men and women what we know without at the same time doing any harm it would solve the problem in one generation. The prostitute is not so because of choice but she becomes one from her ignorance and his importunity in the first place and remains so because of necessity. The clandestine prostitute is nearly always simple minded, and ignorant of the risks and the essential nature of the act. The professional would rarely continue if there was a way out. Most girls go wrong during their minority, many of them because of poverty, some by the desire for finery which they cannot otherwise afford, and some because of adverse social conditions such as poor housing conditions and the lack of privacy in tenement districts, where half a dozen or more not always of the same family are crowded into a room. Economic conditions are also responsible for much. Women are crowding more and more into commercial life and forcing out men who cannot support a family and compete with the single woman in wages. Here she encounters dangers and temptations unknown before and with which she has not learned to cope. She has not learned how to live on department store wages without the aid of some young man who is willing to pay her room rent or buy her clothes for a personal consideration. Many unsophisticated girls going to certain employment agencies are directed to houses of ill fame where they are sometimes induced to stay. These girls are not degenerates—I prefer to think of them as the victims of a faulty educational system or the result of changing economic condition. On the part of men they cannot or will not marry on account of financial considerations, especially when it is so easy and so cheap to gratify their desires without.

In the army and in mining districts this disease overshadows all others as a cause of disability and discharge. In the Phillipines the health certificates for the women and the inspection of the

soldiers has greatly reduced the evil. In private life more men are impotent than we know anything about and we are coming to recognize more and more clearly the causes of the enlarged prostates, the stiff joints, the weak heart valves, and the strictures than we have ever done before. The economic loss in partial and total disability from this one cause is undoubtedly more than from any other two diseases of which we know. In women its results are even worse because its effects are farther reaching. It not only ruins her health but it impairs or stops entirely her productivity and makes her an invalid in a dozen different ways. It is responsible for practically all the one child families. No one knows how much money is spent in trying to get relief but we can get some idea of the burden it entails on the community when we consider the charity patients in our hospitals, the inmates of our poor houses and number of blind asylums filled with its victims. It is a greater hindrance to growth of population than syphilis which maims and destroys its victims rather than preventing their birth. If the citizens are the greatest asset of a country here is another economic loss the amount of which we have no means of estimating.

Relief from these conditions will not come through the police power of the state because laws punishing prostitutes with death have proven ineffectual. Then coupled with the inefficiency of the police power it is bound to be abused in the way of blackmail, extortion, graft and participation. Medical supervision is doubtful because of the difficulty in proving the contagiousness of the individual and because it does not reach the clandestine or the male purveyor. Many would avoid examination and they might be infectious and still have a certificate obtained from unscrupulous persons. The law would help if it required the reporting of cases together with the source of contagion and the names need not be given. This would preserve the professional secrecy and still give us statistical data on the prevalence and the ravages of venereal diseases. Professional secrecy is overworked in these diseases and is wrong in that it places the individual above the public good. The age of consent should be raised in all states to 21 years. In factory districts both sexes should be prohibited from occupying the same houses. Charlatans and Quacks with their deceptive literature should be suppressed. Homes of rescue could be established for those trying to leave the professional ranks of the prostitute. Other states beside Dakota could require a medical certificate showing freedom from these diseases before granting a license to marry.

If such a requirement would not pass at this time parents at least can and should require their son-in-laws to show themselves free from gonorrhea if there is any question of their morality and if fathers appreciated the danger, more of them would do it. At present in all but two states drunkards, epileptics and syphilitics are limited only by their physical capacity in foisting their off-scourings on the rest of the community for support. As a nation we take more care for the breeding of strong and healthy cattle and hogs than we do of children. Nor should paupers in poor-houses or criminals in jail be permitted to marry, and it should be a penal offense to knowingly transmit disease to ones marital partner. Such a law exists in Michigan and sometime it is going to be invoked. You all know how frequently the wife is the innocent sufferer because of the confidence she has in the man she marries and how often he blames her for lack of children when in fact it is because of his impotency or disease in 45 % of the cases. Too often she suffers in ignorance and even when knowledge comes she prefers to bear it in silence rather than reveal his shame. But when a woman infects her husband there is always an awful roar and with justice.

It is because of our lack of knowledge of its prevalence and a proper appreciation of its far reaching results that no more restrictions are thrown around this disease. Ignorance permits widespread and malicious misinformation and it accounts for the fat purses of the venereal charlatan. When we keep this disease so tight in professional secrecy that even we know too little about it, we are protecting the guilty individual at the expense of the innocent sufferer. If venereal diseases were correctly entered in hospital records, if public health books kept account even without mention of names of the individual, we ourselves would better appreciate the evil and its results. Publicity in venereal disease as in others less dangerous and less frequent will mark a revolution in public sentiment. It will upset the traditions of generations and produce a change both in the spirit and the practice of our profession. But at least the masses should know that gonorrhea is the tap root of the diseases of women and that it is the greatest national ill both physically and financially that exists at this time. Sentiment has no legitimate place in preventive medicine and it is up to us to enlighten in this disease just as much and more than in others. Enlightenment has brought wonderful changes in the ravages of tuberculosis—it would bring greater changes in regard to gonorrhea. The very fact that sanitary officers make no mention of venereal disease at all, leads many to regard it as a negligible



matter whereas in fact it is its very extensiveness in every grade and rank of society that makes it so hard to cope with.

My greatest faith is in education. The young girl should learn, preferably from her mother, the essential facts at least, about her sexual organs and their high and sacred function and she should learn them before she gets them in perverted forms from contaminated sources. Many girls getting misinformation from depraved sources and trusting to her instinct fall a victim to the combined forces of her desire. Curiosity and the persuasion of her informant. This, always before maturity of judgment comes and before her parents think of her as budding into womanhood. When a marriageable age she should know that the dissipated man does not make a good husband and she should have the reasons. It is a sin to withhold knowledge that will not only guard her virtue but which affects her future happiness.

The instruction of boys may be more extensive and begun earlier. Most boys begin masturbation before they are twelve years old if they begin at all and 70% of those who contract gonorrhea get it between 15 and 25. Fathers should give the early instruction and their family physician can best give it later. The Y. M. C. A. men have a great field here which they are rapidly utilizing and doing much good. The boy should know the hygiene of his sexual organs and that sexual indulgence is not necessary to health; that irregular intercourse is always dangerous no matter with what girl and that its consequences will effect not only himself but his future wife and children. He should know that continence is the only safe way and that incontinence is responsible for more disease and suffering both mental and physical than all other diseases combined. He should know that venereal diseases are contracted practically always by illicit intercourse and if he should contract it, that he may communicate it to others and for indefinite periods in various ways but usually in the same way in which he got it. He should be urged to stick with his family doctor and be told that it is not a trivial disease that any druggist may treat. Above all he should be warned against the venereal vampires and their terrifying means of extortion. He should not be taught possible means of prophylaxis.

One of the strongest forces against a higher morality is the double standard of morality which at present governs us. There is no forgiveness for the girl after her first fall and the virtuous matron will draw her skirts aside from her while sometimes accepting the man responsible for her fall, as a suitor for a daughters hand. Men generally regard the young rake merely as a sport

and they accept him as an equal when they would not for a minute acknowledge the feminine offender as an equal of his wife or daughter. Indeed it is becoming a common occurrence for our richest men not only to condone the fault in other men but if a title happens to be attached are not only willing to accept them as son-in-laws but hasten to pay a bonus for the chance. Yet it is a matter of history that the aristocracy has been from the earliest times the chief pillar and refuge of the social evils. Considering the double standard of morality from another standpoint we pay little attention to the woman who starts the boy on a life of licentiousness but it is an unwritten law that we may kill the man who does the same for the daughter. We smile indulgently when the black woman seduces the white boy but we mob the black man who outrages the white girl. This double set of moral rules is not fair to the girl and it is bad for the boy.

For the correction of these social evils no law, no sanitary regulation, no moral reform is immediately available; but as a profession we can learn more about these matters ourselves and teach others. Now, I would plead with you that you use your influence, that accurate data may be made available so that we as a profession may appreciate better its prevalence and harmfulness; that you may at every opportune time, teach the laity the nature of the diseases to which they are liable; teach them the habitual sources and how they are spread directly and indirectly; impress the serious and never ending consequences of infection and that most certainly, sooner or later licentiousness will exact its penalty over and over in the coin of pain and sorrow and ill health. Without exception you are in the most favorable position to impart such instruction and your instruction is the most effective. Given a moral and sensible physician and morals and medicine will mix.

#### DISCUSSION.

Dr. M. T. Sudler, of Lawrence.—I think Dr Emley has read a very courageous paper, one that it is well for us to take heed of because it is certainly needed in our ordinary conditions in our country today. There are several points in his paper in which I was especially interested. Of course, he dealt almost entirely with the sociological aspect. When I was in the children's hospital, I saw another side that he didn't mention, and that was the extension to innocent parties who were not adults, and that was the epidemic of small girls who came under our charge. These children, three, four, five, all the way up to ten years of age would come in with this terrible disease, and we found it one of the hardest things to deal with we had. It usually took a period of six to eight weeks in order to get rid of the discharge. Upon looking into the matter and following it up from this point, the fact is, there are authorities who think they never get rid of that disease, and that a small child may carry these organisms to produce trouble when she gets older. At the time I thought we succeeded in curing these children. In others of the larger hospitals the disease was hard to control, spreading from one child to another, so that they refused positively to

take any more girls suffering from this trouble, and there is the point of view which it seems to me would shock almost any man if he understood the facts of that case—that is, not only might he transmit this trouble to innocent persons, his wife and people of the sort, but that this contagion could spread to innocent children and probably infect them all their lives, and I think the doctor is quite right, it is not a question to be dealt with by mock modesty; we should bring it open to sunlight and general education, and that is the only way to adequately deal with this matter.

Dr. R. A. Roberts, of Kansas City.—I don't know as I have anything to add in the way of discussion, but it does seem to me our committee on legislation has a wide field right along this line. I think one thing against coping with this class of disease is the laws under which we have to work. They are known as private diseases, and they are absolutely private in every sense. The patients will come to us and tell us all they want to, they can expose themselves in any manner, they can tell us how they got it, where they got it and how long they had it and all about it, and we dare not open our mouths, we cannot tell it to anybody; we cannot even make a diagnosis on a history sheet and leave it in our office, if I am correctly informed. In my judgment that is absolutely wrong. I will grant that a physician's mouth should be closed ordinarily, but I do maintain it should be so that a physician could be put on the stand and made to swear as to what his diagnosis is in that case. I mean by that, that if a wife wants to know dead sure what is the trouble with her husband, or whether she has had a chance to get the disease and the pain and suffering she is undergoing from that source, she ought to have a perfect right to put that physician on the stand and find out. There is no way under heaven that I can see by which we can put a stop to this or make any impression in that direction as long as everything is so studiously guarded. We cannot even make a diagnosis in our hospitals. If we have a case of epididimitis, orchitis, ophthalmia or any other disease in a grown person, it is put down as orchitis, ophthalmia or conjunctivitis, when it should go down as orchitis (gonorrheal) or endometritis (gonorrheal) or orchitis (syphilitic) or whatever disease of the eye it is. If paralysis or paresis and syphilis is back of it, it should be stated. We are not allowed to make those diagnoses, if I understand the thing correctly. I have taken the privilege in some few instances to do that but I have been told I have made myself liable. I think if we could secure a law, as one doctor has said, to bring this thing into the sunlight—sunlight is good for the germs themselves, and it is good for the disease itself, and it is good for the profession itself—we could accomplish some good but unless we can get a start along in that direction I don't see that we have very much influence or can exert very much influence or do but very little to stop the thing.

Dr. F. L. Abbey, of Newton.—I think if I had heard nothing else I would be well repaid for coming over the hundred miles of road to listen to this paper by the doctor, and the one sentence he used in that paper about professional secrecy being overworked, I think, strikes right at the truth and the core of the whole matter. If we see a man setting fire to our neighbor's hay stack, or breaking into his house with felonious intent, if we see him prepare a cup of poison for someone to drink, no one would question our right to interfere. How does this differ in any respect in intent when a man comes suffering and afflicted with this disease and comes to our neighbor's home or perhaps to our own home and seeks to pollute it. The speaker before me says we are prevented by law from making any disclosure. If there is a law that prevents us doing that in some cases or in almost every case, that law should be changed. There is a higher law, we owe to each other as men and citizens, and a law that is made by God himself, that we should protect each other from such ravages, and we should not hesitate, should we see conditions of that kind coming up. I for one should not hesitate, so far as fear of the punishment of the law, in doing my duty.

Dr. McDonald, of ———:—It seems to me this paper is too valuable to allow it to go by without saying something on it. I feel as though if I



didn't hear another thing during this session, I would be well repaid, as the gentleman before me has said. I cannot see why this paper will not be one of the most valuable papers we will hear during this session. It seems to me the doctors as a body ought to enter more into the moral field and show our appreciation of the moral side of this question, instructing in that way,—of course it is a dirty business all through, but I believe as physicians we have a great duty with our younger patients as they come up, telling them what they ought to do in these matters. I feel very glad I have heard the paper, and I think it will meet very hearty concurrence from all who have listened to it.

Dr. Preston Sterritt, of Kansas City:—I cannot hardly let a paper like this go by without saying something on the subject. I believe it to be, in connection with tuberculosis and alcohol, the three plagues we have confronting us today. We can fight alcohol a little, but the most difficult problem facing the entire people of the world is to keep in check and obliterate, if there is any way possible, venereal diseases. This particular venereal disease is a little different from others such as syphilis, and it is very interesting to read the transactions of the ——— Society at Paris in regard to these diseases. One particular thing about it is that it is hid,—it doesn't become hid when it gets into the eye, but that is about the only mucous membrane in which we can find it showing itself, but it is ordinarily a hidden disease, and it therefore becomes one of the most difficult problems. These people can go around with the sexual organs closed up with no way to see it by the body. Hence I think the question would have to resolve itself into this. It is a very difficult thing, in my judgment, and I have read the question over and over,—it is a very difficult question to check this matter up,—in places they have licensed prostitution,—it seems to me the question should come right straight back to the medical profession, and they should be backed up by the proper municipal authorities and the question dealt with right there. We ought to have the power, we ought to be compelled to make a record of these things so that everybody could be guarded against them,—that is the only thing. It is a very profound question, to my mind, and it is one of the most important.

Dr. J. D. Walthall, of Paola.—This paper shows that the doctor who has prepared it has given a great deal of attention and thought to it, and time in preparing it, and it is left to the doctors and to the medical profession to turn these things to the public. Of course we will hear these, and the doctors who read the State Medical Journal will be able to read this some time, but it occurs to me it is too valuable a paper to keep confined in the profession, and in fact, it is read by people who know too well its damages but I think this paper should be an attempt made, at least, to be made public, to print it in our public papers and let everybody know about it. A great many of the laity consider this subject as a private subject, that this disease is a private disease, but to me and my family and to my friends, so far as it is possible, I make this a perfectly public subject. It is one of the things I think the laity ought to know more about, and it is left to the medical profession to give them the benefit of it. You can talk about your legislation, you can talk about any other means of distributing information, but it rests with the medical profession to make the public perfectly acquainted and to turn on the sunlight of education and experience on this thing and make it not a private one but a public subject, and it will be better understood. I have said to some of my people I wished to make some strong impression upon, that if I had a superstition, it was along the line that God sent his penalties to people in this manner; that one man and one woman was intended to live together and any deviation from that custom was dangerous, and that that is the reason why this is an affliction that comes only to the human race. I would suggest that measures be taken that this paper be made as public as possible and give to the people of the State of Kansas the full benefit of it. In my opinion it would do more towards disseminating knowledge of the dangers of gonorrhea, more than all legislation and all other means that could be done, letting the public know that the doctors of the state are in favor of turning the sunlight of education on all of these lines.



Dr. O. J. Furst, of Peabody:—I want to commend the doctor's paper, and it is hard to say anything alone the line without touching what he has covered. I want to just emphasize one point,—I think if we will begin there until we can make this more public we will be doing our duty better than we have before,—that is, that the average man is ignorant of the enormity of the disease. As the doctor said, they consider it no worse than a bad cold, and if we will impress upon the men who come to us the effects that may come from this disease, impress that upon them fully, I don't believe we will have as much of it. I don't believe the average man is vicious if he knows it. I have not any too much confidence in humanity but I believe that the average man would not infect himself and his posterity with gonorrhea if he knew it, and if you can teach that man that fact every one that comes to your office, I believe you will have been doing a thing you have not done before, and a thing that will be of great benefit to humanity and to posterity.

Dr. B. M. Barnett, of Rosedale:—We have these evils, and it is frequently said that these evils are impossible to be stamped out, but evils as great as this and probably greater have been stamped out, and it is done simply by beginning an agitation. These things are not accomplished in a week, or a month or in a year or a half century. Sometimes I feel like some of the other doctors, that if I should hear nothing further in this society than this paper I would be well repaid for the time I have spent. This is, I believe, the first time I have heard a paper read of such far reaching consequences as the one the doctor read here, and in the manner in which he presented it. Years ago it was said that the evil of drink could not be stamped out; the people who fought that evil in the State of Kansas have found a way out for 25 years and more, and I presume it is pretty well settled now that, as far as Kansas is concerned, the evil of drink has pretty well been stamped out. How was it accomplished?—by simply constant pounding and pounding and pounding,—and today it is beginning in other territories, and it is possible that even within the next two years our neighbor state, the old Bourbon State of Missouri, may go dry. That is what is accomplished by agitation. Right here in the State Society, in the County Society, in the National Association of the doctors of this country, is the place to begin to agitate, and if possible to indicate to our legislators methods of legislation by which we can reach these subjects. I do not encourage this class of practice. I don't see very much of it. It goes to Kansas City, Mo., where men advertise to treat this class of trouble, but I have seen enough of it to know of the evils, and I have seen a few of the cases of which Dr. Sudler spoke in children; I don't pretend to know how those cases are infected, but I have seen them, and I have been positive and know they were cases of that character, and I know how impossible it is, almost, to treat them. Now, if we keep up this agitation we have started at this society of this state in Iola, pound away at it every year, in 25 years we may accomplish what the prohibitionists have accomplished against the demon rum.

Dr. Levi P. Horner, of Wichita:—Much as I was interested in this paper, and have been interested in the subject, I should not have said a word, but for one remark the doctor last speaking made. It was this,—intimating that he paid little attention to these but allowed them to go to men who made a specialty of that thing. I believe he used the word "advertised" that they made a specialty of that thing. The medical profession today is largely responsible for the condition of the public knowledge on this question. It is a question we have recognized for years there should be some information pounded into the heads of the public.

These same specialists that my brother speaks of classes every case of urethritis of every character that comes to their office as gonorrhea. If my brother has paid as close attention to these cases as I have he knows that not to exceed 50 per cent of the so-called cases of gonorrhea, in men at least, are really gonorrhea. And that those self same specialists who advertise to cure those diseases make their reputation by the fact that those cases got well in three or four days, and none of them are gonorrhea. There is another thing the medical profession overlooks right straight along, and that is the very great per cent of so-called leucorrheal vaginal discharges are

gonorrhea. The average gynecologist even doesn't know how great a per cent of them are gonorrhea. The operations I have made for different pelvic troubles were made necessary, nine times in ten, yes, 99 in one hundred, as a result of gonorrhea. How often has every one who has a family practice found a boy or a girl with gonorrhea who is absolutely ignorant, absolutely,—if they knew anything of it, if it were a boy and he knew anything, look upon it as being a slight matter that ten cents worth of something would cure up at once, and the doctors are responsible for that fact. Those very doctors my brother has been letting his patients go to are responsible for that because of the fact they lead their patients to believe they cure them up in one day or two days or three days. The doctor know they don't do it, and it is his duty to keep those patients and take care of them properly and educate them and not let them go to a place where they will be made to believe by some potent drug or by some superior knowledge they have been cured up instantly.

Dr. S. C. Emley, (Closing the discussion):—It was with considerable hesitation I read this paper before this society because I was afraid you would all jump on me for bringing up such a subject. I was lead to write this paper because, when I was at Wichita, a prostitute enticed a boy of 12 years old and she infected that boy, and that boy went to some relatives and was with a little girl, it happened to be because they were crowded for room, he was put with the little girl, and that boy infected that little girl four years of age, and the little girl is a wreck today. Another thing, I know of a fine young man who thought it would be smart to go along with a crowd, and he went along with the bunch of fellows, and he saw some of these things and was horrified, but a little later when he came in contact with a girl he thought was his private property he got infected. There were six other young fellows who got infected one right after the other from that same girl, each one of them thought she was his private property. I could not do a thing. Now as far as I know that girl is still infecting young fellows. There is not anything I could do except to do the best I can for those young fellows, and I must admit that the treatment of this disease in my hands has not been satisfactory, and I have very conscientiously studied how to cure them and have gotten all the information I could about it, but it is not for the cure I wrote this paper; it was, if possible, to enlist your influence that you might begin to educate or agitate the patient with whom you come in contact, and the parents of those children that they might teach them more about these things of which they know nothing, and by the process of education prevent this evil as much as possible.

Moral reforms take a long while. Michigan has had a statute on her books, I believe, ten years, which allows a husband or a wife or a physician to testify in a court of law, or the wife to testify against the husband or the husband against the wife. No case has ever been tried in Michigan as yet. While the law is good and may be instructive to some people who happen to see it, yet our public opinion has not yet reached the point where they consider these things of much value, and physicians come in contact with these people, physicians know more about it, their influence is strongest,—you know better how to reach these people and you are the people who can reach it best if you will only do it.

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Syrup Hydriodic Acid in two teaspoonful doses four times daily has given good results in the treatment of chronic bronchitis.

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Before deciding the necessity for a laparotomy for some vague abdominal condition, where distention is present, empty the bladder. In many cases the acute abdominal distress will disappear.—American Journal of Surgery.

# THE JOURNAL OF THE Kansas Medical Society.

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**JAMES W. MAY,** - - - **EDITOR.**

**J. E. SAWTELL,** { **ASSOCIATE EDITORS** } **CHAS. S. HUFFMAN.**

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## EDITORIAL

Dr. P. S. Mitchell of Iola has consented to gather the medical news of the state for the Journal of the American Medical Association. Anyone having news items of interest is urged to send them to Dr. Mitchell.

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One of the "weak" points in the management of the average hospital is the diet kitchen. Here is prepared the food for the patients who cannot have the ordinary bill of fare. Food for the sick should, besides being prepared in the best manner possible for digestion and assimilation, be made palatable to the highest degree. As nurses are not born but made so from training, just so the art of cooking is not hereditary. Therefore, it should be obligatory for every nurses' training school to have a course on how to prepare food.

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The display of vegetables, fruit and other eatables unprotected from the dust of the streets by numbers of grocery men, which is in direct violation of the law, is as filthy as it is disease breeding. How easy it is for bacteria laden debris in blowing about to find itself a resting place upon the food stuffs and then



being directly transmitted to the alimentary canal. Is it any wonder that there are so many cases of gastro-intestinal disorders of bacterial origin? It is the plain duty of the sanitary officers to protect the communities from this danger, and that at once, without procrastination.

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When we consider the number of deaths from diseases which in a vast number of cases are preventable, it almost appalls one. We should hesitate in our wild scramble to discover something new, which event would hand down our names to posterity, but try and educate the laity in the prevention of typhoid fever, small pox, tuberculosis and many other communicable diseases. This is not meant to carry the idea of non-progression or original research, but to exert ourselves to the utmost in stamping out diseases which we know can be prevented by proper measures.

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Is diphtheritic antitoxin harmless? This question has been before us and discussed pro and con for some time. Certainly the advocates of large dosage have a great deal of evidence. to the contrary. Quite a number of cases of diphtheria have been reported where the amount of antitoxine administered in a single case was 50,000 to 75,000 units with recovery and no complications. In one case 110,000 units were given, followed by recovery. Considering this evidence, it would seem that the wise procedure in a well marked case would be to give at least 5,000 units as an initial dose followed by rapidly ascending doses without limit until marked improvement takes place.

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The International Congress on Tuberculosis met in Washington in September to discuss and promulgate means for the prevention of this malady. It would seem that one of the all important questions which should confront us as medical men is the establishment of sanatoria in all the large cities of the world for the care of tuberculosis patients. Philadelphia is the only large city in the United States that maintains a separate hospital or sanitarium for the care of these cases. It is not an uncommon sight in almost all of the public hospitals in this country to find patients with tuberculosis in the same ward with others. The result is plain to be seen, a spread of the infection. When the authorities in all of the large municipalities can be made to see the danger of the white plague, then some definite action will be taken. Our duty is plain, educate the municipal authorities.



More publicity should be given to fatalities resulting from the practice of quackery and charlatanism, not only in the medical press, which is not read by the people at large, but also in the lay papers, magazines and periodicals, which reach the masses within whom we are trying to educate the necessity of potent legislation to control and establish the scientific treatment of diseases. Should a boatload of people be drowned by reason of an unskilled, unlicensed pilot, the press, both in reports of the disaster and in lengthy editorials, would condemn the pilot. An occurrence of this kind fortunately happens but seldom. Would-be pilots of the health and well-being of mankind are extant always, and more people are guided to disaster upon the rocks of ill-health by the uneducated, unscientific charlatans throughout this country, than is occasioned by any other cause of misplaced confidence. We sit complacently in our offices and read lengthy essays regarding the prevention of diseases; nod our heads in approval thereof, but in the meantime few of the laity know what the medical fraternity are trying to accomplish for the laity themselves. The editors of the daily newspapers should be urged to interest themselves in this great undertaking.

The present great convention being held in Washington, D. C., to formulate plans for the suppression of Tuberculosis is spoken of very sparsely in our daily newspapers. Its actions should be elaborated upon to the public so that they may become educated and enlightened and thereby awakened to the necessity of collaboration with those who have their best interests at heart. Legislators, as rule, at present seem to have the idea that when the medical fraternity desire laws enacted, it is from a selfish standpoint, or with a jealous motive. Publicity of medical measures to promote the healthfulness of the populace would enlighten the voters to elect representatives to the several legislatures whose views would coincide with the teachings of the medical fraternity and the conclusions reached by the masses by reason of increased knowledge and discarded prejudices, which education has a tendency to dissipate, would make them sympathizers and assistants in the noble work.



## CLINICAL NOTES

Judiciously placed sutures are far more satisfactory in arresting hemorrhage from a scalp wound than is an attempt at multiple ligation.—American Journal Surgery.

**Gargle for Chronic Pharyngitis.**—The following is credited to Eudler in *Journal de Medecine de Paris*, for March 14, 1908:

℞ Zinc sulphate.....gr. iii;  
Peppermint water.....℥ii.

Sig.: Use as a gargle three or four times a day.

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Strong antiseptic solutions should be avoided in dressing scalp wounds. For "wet dressings" Thiersch's (boro-salicylic) or Burow's (aluminum acetat) solution is sufficiently antiseptic.

—American Journal Surgery.

**Catarrhal Conjunctivitis.**—The application of a yellow oxide of mercury ointment of the following composition has given good results in the treatment of catarrhal conjunctivitis in the hands of M. Mallet (*Bulletin general de therapeutique*, June 15, 1908):

℞ Yellow oxide of mercury.....gr. vi;  
Liquid petrolatum.....℥iss;  
Lanolin.....℥iiiss.

M.

Gentle massage of the eyelids is to be recommended in association with this treatment.

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**Diabetic Coma.**—After the withdrawal of a certain amount of blood in diabetic coma of acidæmia it is advisable to inject into the veins solutions that approximate normal blood plasma rather than either physiological saline solution or saline solution with a large amount of sodium bicarbonate. The following is Rigner's solution, which may be used for this purpose:

℞ Sodium chloride.....gr. cxxxv;  
Calcium chloride.....gr. iv;  
Potassium chloride.....gr. viiss;  
Sodium bicarbonate.....gr. iii.

M. Fiat chartula 1.

Sig. To be added to a quart of distilled water.

This solution may be made into sterilized tablets and kept ready for use.—*Journal of the American Medical Association*.

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**Radium Salts for Cancer.**—F. H. Williams, Boston, (*Journal A. M. A.*, September 12), gives his experience with the use of radium in the treatment of some superficial cancers and other cutaneous disorders. The chief therapeutic effects seem to be from the beta rays, fourteen times as much of which as of the gamma rays are given off, as shown by the fluorescence produced. Besides cancers, it seemed to be useful in acne, psoriasis,

eczema, warts and keloid, and gave rather encouraging results in two cases of trachoma. In 68 cases of epithelioma, with an average duration before treatment of four and one-half years, the lesions healed in 55 patients; 4 are under treatment; in 1 healing failed; and 8 stopped treatment, all, with one exception, doing well at the time. One case is reported. In his method, the capsule containing 50 mg. of pure radium bromid, on a handle a foot long or more, was applied over each area treated, for a period varying from one-half to three and sometimes four minutes, from one to three times a week (less often after healing has begun), according to the case. His conclusions are given as follows: "1. The radiations from radium are uniform in quality and quantity and thus this remedy has a great advantage over the x-rays in efficiency and safety. 2. The gamma rays from radium are useful in some cases for relieving pain. They have great penetrating power. When they are used as an analgesic the beta rays should be excluded or the patient may be burned, partly because the proportion of gamma rays is so much smaller than that of the beta rays that the exposure must be much longer, when the gamma rays are used, to make them effective. 3. The beta rays from radium are the useful rays in the treatment of rodent ulcers, epitheliomas and other superficial diseases. They can be applied in the mouth and other cavities. 4. Radium should be used early, and in suitable amount and strength. The treatment is painless and leaves least scar. 5. Radium does not produce as good results in cases in which an operation has first been done, or scraping, caustic or other irritating treatment has been used, or the x-rays have been applied. 6. Improvement follows the use of radium more promptly in many cases than the use of the x-rays, and the total duration of treatment by radium, though sometimes long, is much shorter than with the x-rays. In some cases success has followed the use of radium when treatment by the x-rays has failed. 7. A surprisingly large proportion of external cancers, especially epitheliomas, having healed and remained healed for some years under treatment by radium, and my experience thus far indicates that in certain cases of external new growths it is a better remedy than those previously at our command. 8. Recurrences follow all methods of treatment, and radium is no exception, but, so far as present experience goes, this is unusual, and they have yielded to further treatment by radium. 9. The disadvantage of radium is its cost to the physician."

An excellent eye wash for home use is,

R Glyco-Thymolini..... ʒi;  
 Acidi Boracici (crystals) sat. sol. q. s. ad..... ʒv.

Sig: Apply one or two dropper fulls to the eye morning and evening using it warm.

If much irritability of the eyes should follow (temporarily), the following is more soothing and has a better psychological effect:

R Glyco-Thymolini..... ʒ ss;  
 Cocain Hyd chl..... gr. i;  
 Acidi Borici (crystals)

Saturated solution q. s. ad..... ʒiv.

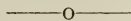
Sig: Put one dropper full in the affected eye morning, noon and night.

The crystals of boric acid are much more preferable than the C. P. in an eye wash.

In case the patient cannot evert the lids, they can apply the eye wash by pulling the lower lid down and putting a few drops in the cul-de-sac and then wink the eye, repeating this a number of times, or until the dropper full of the medicine is used.

Bathing the eye freely with water previously boiled and as warm as they can endure previously to or following the treatment should be ordered, and if much secretion, the eyes should be bathed with the warm water between times. Cleanliness and *vis natura medicatrix*, will do the work.

J. E. M.



**Hemorrhoid Operations.**—J. D. Singley, Pittsburg (Journal A. M. A., September 19), points out the danger in the ligature method of treating piles from possible infection of veins, he having observed one case of fatal pyemia, and a number of cases of embolism following this apparently simple operation by capable and clean surgeons. There is certainly a definite though low mortality that should cause it to be discarded in favor of better methods. The Whitehead operation is most satisfactory from the operator's point of view, but it may cause simple or infection embolism, there is a risk of stricture and also of incontinence which should outweigh its operative attractiveness. The clamp and cautery method, in his opinion, is free from these objections if properly performed. The hemorrhoidal masses should all be caught and brought down before any of them are cauterized, the clamp should be applied in the long axis of the bowel to avoid annular stricture, and it is better to burn away the clamped hemorrhoids instead of cutting them off before cauterizing, to avoid possible hemorrhage and infection. While less attractive as a surgical procedure,



the freedom from the objections stated above, he thinks, should make it the operation of choice in almost every case.

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A good dry dressing powder can be made by mixing 75 parts of boracic acid with 25 parts of acetanilid.

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**Serum Diagnosis of Syphilis.**—Udo J. Wile, Berlin, Germany (Journal A. M. A., October 3), gives substantially the following conclusions, deduced from investigation of a hundred cases in which both serum and urine were tested for the presence of complement-binding substances in syphilis, to compare the relative value of each in the diagnosis and if possible show the influence of treatment received on the presence or absence of the reaction. Seventy-six of the 100 individuals were or had been syphilitic, 24 were control or normal cases. 1. The urine in a large percentage of syphilitics contained substances behaving in the same way as the antibodies in the serum of the same patients. 2. These substances seem to appear a little later in the urine than in the serum and at times are present in one and not in the other. 3. The diagnostic value of the reaction in the urine must, for the present, be viewed with caution, since in 2 per cent of his case a positive reaction occurred in the urine, while the serum was negative. 4. In both serum and urine these substances tend to disappear under vigorous specific treatment.

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**Prolapsus of Rectum.**—L. J. Hirschman, Detroit (Journal A. M. A., October 3), reports two cases of hysterectomy which emphasize one of the sequels of this operation, which, he thinks, has not received sufficient attention. In both cases there was more or less rectal prolapse which required a second operation. From these two cases he deduces that in patients requiring hysterectomy, who have suffered from chronic constipation, the possibility of postoperative prolapse of the rectum and sigmoid must be considered. In such patients the removal of the uterus deprives the rectum of an important anterior support, and the broad ligaments should be brought together whenever possible. Further, if in these cases laceration or rectocele exists perineorrhaphy and posterior colporrhaphy should be performed. If there is any tendency to prolapse of the rectum or sigmoid, mesosigmoidopexy should be done as a prophylactic measure. Mesosigmoidopexy should be the operation of choice in any case of complete prolapse of the rectum or sigmoid, whether following hysterectomy

or from other causes, "as it holds the sigmoid in place by its natural support, its own mesentery, which being double its original thickness, becomes twice as strong a support. By not causing a fixation of the bowel to the abdominal or pelvic wall, its natural mobility is not interfered with, and the normal peristaltic movements are not interfered with."

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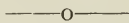
**Exophthalmic Goiter.**—An interesting historical review of the earlier literature of exophthalmic goiter is given by G. Dock, Ann Arbor, in the *Journal A. M. A.*, October 3. He first remarks that there are few diseases in regard to the early history of which so many errors and misconceptions are found in text-books and current literature, hence the advisability of a revision of the historical details in the light of the knowledge of the present. Without going back beyond Morgagni, since the earlier references are unimportant, he finds nothing in the references of Buschan or from other sources that seems to him to be this disease mentioned in Morgagni's works. He next reproduces in full the cases reported by Flanjani, on the strength of which he has been credited with the first recognition of the disease, and which certainly appear hardly sufficient to support the claim. Parry, "the old Bath Physician" of Osler, seems to have published his first contribution to the literature of the disease in his "Elements of Pathology and Therapeutics" in 1815, and Dock gives his account of his first case, observed in 1786, in full. He was an observer rather than a generalizer, but he suggested some connection between the heart disease and the goiter. Adelman, who wrote in 1828, described some cases of what may have been this disorder, but the next important epoch is that of Graves, whose observations on exophthalmic goiter were first published in 1835. His report had no immediate effect in stimulating others, and owes most of its fame to the subsequent works of Stokes and still more of Trousseau. With nothing of value in the meantime, we come to the article by Basedow (1840), in which, for the first time in the history of the disease, we have a clear description, a study of the literature and an attempt to explain the nature of the disease. A few weeks later appeared an article by Brueck reporting five cases, but evidently from Dock's account not a very valuable contribution. From this time the literature of exophthalmic goiter began to increase. There were three or four doubtful reports in the eighteenth century; 10, many of which were very doubtful, in the nineteenth up to 1835. From 1840 to 1845 there were 6; in the next five years 17, and the next decades show 61, 159, 248 and 456 respectively. Koher, in 1902, collected 1,423 titles. Special mention is made of the work of Stokes in 1854, and of the discussion in the Paris Academy of Medicine in 1860, in which Trousseau proposed the designation "frustes" for the imper-

fectly developed cases of the disease, a term which Dock sees no good reason for perpetuating. A list of the proposed names for the disorder in their chronologic order is given, and he finds that the name, "Basedow's disease", has the priority over any other that is free from serious objection and is, moreover, the one now most widely used, and that none of the later ones have any real advantage over it in accuracy. It is an eponym, but it has in this fact the great advantage that it suggests no theory. Dock remarks on the slow development of our knowledge of this disorder as compared with that of a related disease, myxedema. From Parry to Marie and Mobius is sixty years, while only twenty had elapsed after the first description by Gull and the thorough elucidation of the pathologic anatomy and specific treatment of myxedema. It is not even yet the time to draw final conclusions as to the pathology and etiology of exophthalmic goiter, but he thinks that the investigations now being made and with the methods at our command we shall soon be able to do so.

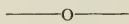


## NEWS NOTES

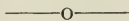
Dr. Wm. McDougal has located at Osawatomie, Kansas.



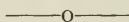
Dr. V. H. Baulteon has located at Reserve, Kansas.



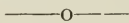
Dr. C. M. Stemen and wife have returned from a hunting trip in Alaska.



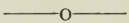
The Northeast Kansas Medical Society meets at Atchison Oct. 8th. An attractive program has been arranged.



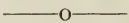
Dr. Geo. H. Hobson of Valley Falls Kansas was married recently to Miss Lorena Smith of Kansas City, Kansas.



Dr. J. A. Fulton, Sec'y of the Kansas City, Kansas, Board of Health and Dr. Grover Sharrard attended the Congress on Tuberculosis at Washington D. C.



The time is now at hand when physicians doing a general practice will find that a closed buggy top is almost a necessity when driving in stormy weather. The Rain or Shine Top Co., of Wichita makes an ideal one that is inexpensive.



Program Rice County Medical Society Nov. 19th. Lyons, Preventative Medicine, Dr. L. E. Vermillion; Rhinitis, Dr. F. E. Wallace; Paper, Dr. G. E. Bush. Dec. 17th Lyons, The Ideal County Medical Society, Dr. C. J. Forney; Election of officers.

The South-east Kansas Medical Society will hold its next meeting at Independence Oct. 13th. A fine program has been arranged and a good attendance is predicted. The following is the program:

G. A. Blasdel, M. D. Garnet, Kansas, "Hay Fever". N. C. Morrow, M. D. Altamont, Kansas, "The Ochsner Treatment of Appendicitis." M. F. Jarret, M. D. Ft. Scott, Kansas, "Subject not announced". P. S. Mitchell, M. D. Iola, Kansas, "Drop Stitches, or a plea for more rationality and dignity in our talks to the laity"; A. H. Fortner, M. D. Independence, Kansas, "The Contagion of Health"; Charles Huffman, M. D. Columbus, Kansas, "Subject not announced". Clinical Cases. 5 P. M. Automobile Ride. 7:30 P. M. Banquet. 8:30 P. M. Jabez N. Jackson, M. D. Kansas City, Mo. "Cancer of the Female Breast"; J. A. Rader, M. D. Caney, Kansas, "The Law of Compensation"; Hugh B. Caffey, M. D. Pittsburg, Kansas, "Report of a case of Splenomedullary Leukemia treated with Arsenic and x-rays." (Synopsis) Early symptoms, necessity of co-operation of patient to carry out tedious treatment. Method of administering arsenic. Method of using x-rays. Report of case. Conclusions.

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One of the largest medical meetings of the west will take place in Kansas City, Mo. October 19-20-21 when the South-west Medical Association holds its third annual meeting. The sessions will be held at the Coates House, 11th and Broadway and the Casino music hall in the immediate vicinity. Clinics will be held at the various hospitals in the two Kansas Cities. Dr. Jno. Punton, Altman Bldg., Kansas City, Mo., is chairman of the committee on arrangements. Following is the program:

#### SECTION ON SURGERY.

##### Chairman's Address

1. "The Operative Treatment of Hemorrhoids" Dr. W. H. Stauffer, St. Louis, Mo.
2. "Normal Salt Solution in Septic Conditions of the Peritoneum" Dr. J. M. Taylor, Fort Smith, Ark.
3. "Chorion Epithelioma" Drs. A. L. Blesh and C. B. Lee, Oklahoma City, Okla.
4. "A Discussion of the Blood Supply of the Ureters, with Especial Reference to Wertheim's Operation for Cancer of the Uterus" Dr. Jno. T. Moore, Galveston Tex.
5. "Renal and Vesical Calculi", Dr. J. E. Gilcreest, Gainesville, Tex.
6. "The Treatment of Gastric Ulcer by Pyloric Exclusion" Dr. Willard Bartlett, St. Louis, Mo.
7. "A case of Cancer of the Esophagus" Dr. A. Watkins, Little Rock, Ark.
8. "Renal Calculus" Dr. D. W. Basham, Wichita, Kan.
- 9.



"Cholelithiasis" Dr. David Myers, Lawton, Okla. 10. "Compound Dislocation of the Astragalus" Dr. C. H. Wallace, St. Joseph, Mo. 11. "The Co-Existence of the Symptoms of Appendicitis and Right Kidney and Ureteral Irritation" Dr. LeRoy Long, McAlester, Okla. 12. "Paget's Disease of the Nipple" Dr. Jno. T. Wilson, Sherman, Tex. 13. "The Roentgen Method of Diagnosis in Calculi of the Genito-Urinary Tract," with report of cases Dr. E. H. Skinner, Kansas City, Mo.

#### SECTION ON GENERAL MEDICINE.

Chairman's Address, Dr. F. B. Young, Springdale, Ark. 1. "What is to Become of the General Practitioner", Dr. E. O. Barker, Guthrie, Okla. 2. "A Critical Review of Erlich's Side Chain Theory of Immunity", Dr. J. W. McLaughlin, Austin, Texas. 3. "Insanity as the World Sees It," Dr. C. C. Goddard, President Kansas State Medical Society, Leavenworth, Kas. Discussion opened by Dr. John Punton, Kansas City, Mo. 4. "Arteriosclerosis", Dr. J. T. Clegg, President Arkansas State Medical Society, Siloam Springs, Ark. 5. Paper, Dr. Chas. W. Fisk, Kingfisher, Okla. 6. "Tuberculin and Tuberculin Therapy", Dr. Louis M. Warfield, St. Louis, Mo. 7. "The Relation of Physicians to Quarantine Measures", Dr. O. P. Davis, Topeka, Kas. 8. "Malignant Growths of the Rectum", Dr. W. J. McGill, St. Joseph, Mo. 9. "Diet in Hyperacidity," Dr. J. M. Bell, St. Joseph, Mo. 10. "The State's Duty to the Physician," Dr. A. H. Madry, Aurora, Mo. 11. "Chorea", Dr. M. A. Kelso, Enid, Okla. 12. "Facial Neuralgia," Dr. Joe Becton, Greenville, Texas. 13. "Treatment of Cancer of the Rectum," Dr. R. H. Barnes, St. Louis, Mo. 14. "The Diagnosis of Extra-uterine Gestation," Dr. A. R. Kieffer, President Missouri State Medical Association, St. Louis, Mo. 15. "Differential Diagnosis between Pericolitis and Chronic Appendicitis," Dr. Herman E. Pearse, Kansas City, Mo.

#### SECTION ON EYE, EAR, NOSE AND THROAT.

Chairman's Address. 1. "The Treatment of Dacryo Blenorrhoea and Dacro Cystitis," Dr. L. H. Buxton, Oklahoma City, Okla. 2. "Tuberculosis of Larynx," Report of cases, Dr. Edward H. Carey, Dallas, Texas. Discussion opened by Dr. A. W. McAlester, Kansas City, Mo. 3. "Acute Otitis Media," Dr. J. C. Brown, Wichita, Kansas. Discussion opened by Dr. R. S. Magee, Topeka, Kansas. 4. Acute Mastoiditis and the Necessity for an Early Operation," Dr. Robt. E. Moss, San Antonio, Texas. Discussion opened by Dr. Z. N. Short, Hot Springs,

Ark. 5. "Raynaud's Disease Involving the Upper Eye," Dr. R. E. Runkle, El Reno, Okla. Discussion opened by Frank Boyd, Fort Worth, Texas. 6. Paper (Title to be announced), Dr. S. Vinsonhaler, Little Rock, Ark. Discussion opened by iDr. John T. Hammill, Guthrie, Okla. 7. "Otitic Brain Abscess," Dr. Pierre F. Leonard, St. Joseph, Mo. Discussion opened by Dr. H. Moulton, Fort Smith, Ark. 8. Inflammation of the Lingual Tonsil, with Report of Case, Dr. J. S. Wever, Kansas City, Mo. Discussion opened by Dr. A. Alt, St. Louis, Mo.

The Kansas City physicians are making great plans for the social entertainment of those attending, including all the ladies as follows:

Monday evening, a banquet for the wives and their husbands at the Coates House; Tuesday afternoon, an automobile ride for the ladies through the beautiful parks and boulevards, with tea served at the Country Club under the direction of the Ladies' Committee; Tuesday evening, a smoker for the physicians; and Wednesday evening, a grand reception and ball for all who are in attendance. Keep these things in mind, and take your wife with you.

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### OBITUARY.

Dr. J. P. Scoles died at his home in Galena, Kansas, Aug. 16, 1908. His age being 69 years, 11 months and 7 days. He was born in Knox County, Ohio. Educated at Fredericktown, Ohio, and studied medicine with an Uncle of his who lived at that place. He was married to a Miss Rummel, June 20, 1860, who died June 18, 1861. He enlisted in Company "G" 31 Iowa Vol. Inf. in the fall of 1862 and served through the war. He married Miss M. J. Tallman, Feb. 9, 1869, and moved to Newton County, Missouri, in 1870, and associated himself with Dr. C. H. Davis, of Neosho, Missouri, for two years, then he moved to Lowell, Kansas. He graduated from the College of Physicians and Surgeons, St. Joseph, Missouri, in 1880, and moved to Galena, Kansas, where he continued to reside up to the time of his death. At the time of his death he was President of the Cherokee County Medical Society, and had been ever since its organization. Also member of the Board of U. S. Pension Examining Surgeons. He was President of the Building Committee of the M. E. Church, which has just completed a \$20,000.00 building in which a new memorial window has been placed in his honor. He was also a member of the G. A. R. and Masonic Organizations.

Dr. Scoles was one of the best Society workers in this part of the State, and had the confidence and respect of all his fellow practitioners as well as the good will of his fellow citizens in the town in which he resided.

C. S. H.

Dr. John Martin Hamme, was born in York, Pennsylvania, in 1864. Graduated in the City High School, from there went to LaFayette College, Easton, Pennsylvania, where he graduated with honors in the scientific course. He then entered the Medical Department of the University of Pennsylvania, and graduated near the head of his class in '89. In the summer of 1900 he came to Cottonwood Falls, Kansas, to practice. In 1904 he entered into a partnership with Dr. C. L. Conoway, of that place, which partnership lasted until his death. In 1904 he was elected State Senator, to represent the 23rd District.

Dr. Hamme had a keen and brilliant mind, and was a physician and surgeon of marked ability. He made many friends and kept them. He was a member of the Masonic bodies, "York" and "Scottish Rite". His body was sent to York, Pennsylvania, for burial, escorted by Hon. J. H. Mercer, representing the Masonic Lodge of his home, and P. J. Norton, of Cottonwood Falls, representing the higher Masonic Bodies. Dr. Hamme was a member of the County, State and American Medical Societies. He is survived by his mother.

C. S. H.

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The South-west Kansas Medical Society held its meeting at Garden City, Kansas, October 6th. The following program was given:

Call to order by the President 1. Report of a case by Dr. Otis Thompson of Dodge City. Discussion. 2. Paper by Dr. Chas. Cahill of Rozel, Kan. Title, "Headache and its Meaning." Discussion. 3. Paper by Dr. W. J. Stilson of Garden City. Title, "Ecalmpsia," with report of case. 4. Paper by Dr. Blanche Workman, Buffalo, N. Y., describing her work in the service of the Salvation Army. 5. A brief talk by Dr. G. H. Johnston of Lakin on The Help the Statè Board should have from the Profession. 6. Paper by Dr. J. C. Brown of Wichita. Title, "Iritis". 7. Paper by Dr. C. E. Ross of Wichita. Title, "Dementia-Praecox." 8. Case report by Dr. O. L. Helwig of Garden City. Title, "Streptococcus Poisoning in Puerprism," also clinic. 9. Paper by Dr. C. E. McCarty, title to be announced.

Banquet in the evening C. P. Bartley, Secretary.

# THE JOURNAL

## OF THE

# Kansas Medical Society.

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No. 11

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### HYSTERIA, WITH REPORT OF CASES.

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O. S. HUBBARD, M. D., Parsons, Kansas.

Read Before the Kansas State Medical Society at Iola May 6, 1908.

This disease has been defined as "A condition in which ideas control the body and produce morbid changes in its functions." There has been and still is somewhat of a tendency to regard hysteria as wholly an attempt to deceive, to excite sympathy, to attract attention, or to do something unusual. It is observed usually in young women of small mental capacity under the strain of some emotional shock. This conception of hysteria is quite erroneous and although hysteria occurs most frequently in unstable young women it is not limited to the female sex by any means.

Hysterical people are usually emotional and may have a morbid desire for sympathy, they may practice deception of all kinds to draw attention to their sufferings and to keep up the solicitude of their friends; conceding this much, and admitting that fits of temper are sometimes called hysteria, it is well to reiterate that hysteria is a real disease just as surely as mania, chorea, measles, or typhoid fever.

Its etiology is varied, heredity being a large factor, with some shock, emotional or physical as an inciting element. Railroad accidents etc. frequently bring about "traumatic hysteria" which when connected with suits for damage excite so much suspicion.

The pathology of hysteria is psychical though there may be some change in the cells of the cerebral cortex and is described as a "fixed idea", this "fixed idea", in some way, not understood, to a great extent dominates the mind and through it the body; the treatment which is largely psychical, must be directed toward the correction or removal of this "fixed idea"; just as the treat-



ment of organic disease with a well-understood pathology must be directed at the morbid physical condition or at its results. It is in hysteria that the charlatan with his spectacular methods and positive statements, the Christian Scientist with his ability to direct the mind away from the body and the holy relics with their halo of sacred mystery bring about remarkable and positive cures.

The symptoms of hysteria are so varied that one authority says "it may mimic all other maladies." With it may occur symptoms ranging from slight sensory, motor or mental changes to such conditions as dermatographia, hemi-anesthesia, total blindness, severe convulsions, loss of memory and will power, well marked contractures, high fever, aphonia, persistent even fatal vomiting and diarrhoea, phantom tumors, and paralysis so complete as to render the victim a helpless invalid.

The diagnosis of hysteria is not always easy, in fact it may be very difficult; on the other hand some cases are so evident that any one who keeps the condition in mind can recognize it at a glance.

In diagnosis three serious mistakes are to be guarded against; (1) The failure to recognize the disease which may so closely resemble organic disease as to deceive the very elect. (2) the diagnosing of hysteria as a cloak to hide ignorance of the real condition and, (3) the failure to recognize organic disease with its results when complicated with hysteria.

Several cases of hysteria, in patients of the Parsons State Hospital have come under my observation recently, and as they are of considerable interest to me I desire to report them.

Case No. 1. Male, aged 22, an epileptic, feeble minded but reads and writes fairly well, quite eccentric and inclined to be solitary. Has a slight hemiplegia but physical development is good; he has been in the hospital about three years. There is a neurotic taint in his family. On Aug. 26 last, he had a well marked hysterical manifestation. He had been in his usual condition until a few days preceding when he had four epileptic seizures in one night and was considerably prostrated. During the morning of the 26th he had some trouble with another boy and became much excited and angry but did his regular work about the cottage as usual.

During the afternoon he had some difficulty in talking and swallowing and expressed the opinion that that he would soon be unable to talk at all. At bedtime he could not speak nor talk, was quite rigid and had to be carried up stairs; he indicated by

signs that the trouble was in his throat and appeared to be suffering. His condition was such as to alarm his attendant and his condition was reported as serious. Examination showed much of the trouble to be located in his throat, he spoke only a few words and those only after suggestion and vigorous and painful massage of the neck. During the night he was almost perfectly quiet but did not sleep much if at all, the next morning his condition was about the same but after thorough massage and strong suggestion he was able to speak a few words and swallow water. On being gotten out of bed and being told that he could walk and must do so he was able to do so without much difficulty. During the day under suggestion, bitter medicine, and massage of the throat, the ability to talk and swallow gradually returned. This boy had widespread blunting of sensibility to pain but no absolute anesthesia. The only hyperesthetic area noted was over the testicles, which were very sensitive to pressure.

The reflexes were present and did not appear to be much modified. Marked dermatographia was present. Simulation is hardly to be considered in this case, the apprehension of the patient was so evident that a look at his eyes showed that he considered his condition serious.

A later examination showed moderate narrowing of the visual field in both eyes, no anesthetic areas, testicles very sensitive to pressure, dermatographia present but not marked. He complained of some difficulty in swallowing but has a normal throat. Several times since when unwell or excited he has had mild attacks of similar nature. Previously I had observed what were probably hysterical symptoms but were unrecognized, one especially giving considerable worry as it occurred just after the extraction of teeth when cocaine had been used rather freely.

Several years ago I observed a case of hysterical aphonia, with very severe convulsions and difficulty in breathing, occurring in a nervous young woman which was cured by painful Farradism applied to the back of the neck.

Case No. 2 Female, aged 16, admitted early in Aug., adjudged to be an insane epileptic. She is quite intelligent, reads and writes and is, at present, rather a favorite about the hospital. Her history states that she had her first convulsion in April last but she is said to have had fainting spells for some years, since April she has had a considerable number of attacks after which she would lie unconscious for some time, probably several hours. The doctor who signed her commitment papers states that he saw her in ten epileptic seizures.

On the night of Aug. 29th I was called to see her, she having had 6 convulsions in quick succession, these were of a comparatively mild type but the nurse's attention had been drawn by the rigidity and other peculiarities of the convulsion. She was apparently unconscious, lying on her side with her clenched fists drawn up to her face, and so rigid that I could straighten her arms only by exerting my full strength. The eyes were tightly closed with the lids twitching and on attempting to raise the lids resistance was marked which is quite different in epilepsy. The eyeballs were rolled up and the pupils were active. The reflexes were present. She did not respond to pin pricking. A diagnosis of hysteria was made and a cold spongee bath ordered which stopped the convulsions; during the remainder of the night she rested well. The next day she was cross and dull but by night had returned to about her usual condition.

On Sept. 3d she had a convulsion following a period of depression and when coming out of it began to tear her clothing and on being prevented became violent, fought fiercely and used bad language. She remained in bed the following day and refused to eat, the next morning was quiet but said she could not open her eyes, but after being told positively that there was nothing wrong with her eyes and the lids being raised by force she was soon persuaded to use them and was in a short time in her usual mood.

Sept. 13th while out walking with her attendants and other patients she became excited and attempted to run away saying that she wished to kill herself by getting in front of a locomotive which could be seen in the distance. She was controlled at this time with difficulty, but the attempt was made when there was no possibility of its success, suggesting a morbid desire to attract attention or to do something startling. Being controlled, she soon became unconscious and had mild convulsions, and had to be carried into the hospital on a stretcher; about an hour later she became very unruly, cried, tore out her hair by handfuls, bit her fingers, bumped her head on the floor and was very violent, requiring the attention of half a dozen women; while in this condition she was held with difficulty but on being given a few whiffs of ammonia went quietly to sleep. Some hours later the same scene was repeated with the same treatment and the same result, since which time she has had no serious attack, but has had one or two outbreaks of temper, starting in a quarrel with other patients, during which she was noisy and rude and was not in a good mood

for several days, evidently taking pride in her outbreak at first, but later becoming much ashamed and very penitent.

Ordinarily this girl is quiet, modest and good tempered, goes to school and is quite a favorite and has recently been placed on our best ward, she is however, very emotional and subject to fits of depression. She says she has made up her mind to have no more such spells and I have assured her that she can avoid having them if she really wishes to do so.

Examination reveals little of interest except some chest deformity, a slight and uncertain difference in sensitiveness in the two sides, and a moderately contracted visual field. We have found no evidence of epilepsy in this girl and believe that her condition is pure hysteria, and that with good surroundings and encouragement the prognosis is favorable.

Case No. 3. Female age 19. Bright and a little bold, sent from Kansas City late in Aug. where she had been picked up by some mission workers. She told a story about leaving Hutchinson, losing consciousness on the train, and knowing nothing more till she found herself in Kansas City the second day later. She also said that for some years she had been a chorus girl, traveling about, singing, dancing etc. but this story must be taken with the proverbial grain of salt, but at any rate her history is indefinite and incomplete. She claims to have had some kind of spells for a long time.

Examination showed a rather small girl, not very well developed, no special findings except tenderness on the left side of the abdomen and extending into the pelvis. Conversation tended to show that she was a rather forward girl, of emotional temperament, pleased with show life, anxious to attract attention and telling a story which was inconsistent in details and which was partly, at least, gotten up for the occasion.

While under observation in Kansas City, immediately before coming to the hospital she was seen in an unconscious state which lasted for four hours. Within a few days after admission she had four seizures each one being precipitated by some emotional disturbance, usually anger over not being allowed to do as she pleased. These attacks did not much resemble an epileptic seizure and were characterized by moderate convulsion, strong flexion of the limbs, extreme rigidity, loss of consciousness and dermographia.

Suggestion and complete lack of sympathy has seemed to control the attacks, she has had none for more than six months.

This girl has been in school, is alert and active, but is unstable,



changeable and hyperemotional, and likes to be in the lime light; she is inclined to consider herself better than other patients and to dictate to them, or, in hospital parlance, is a "ward boss".

We have seen nothing to make us think that this girl is epileptic, the case is probably pure hysteria.

Case No. 4. Female, married, age 18, admitted Nov. 3d. This woman is small, looks to be about 16 and when admitted was not in very good condition. Her perception is good but she cannot read nor write. Her conversation suggests a rather shallow mind which has never been developed, she in many ways resembles a pert child. The family history is vague but there is some hereditary taint. She gives a history of privation and mistreatment during her younger days and the fact that she never learned to read or write tends to confirm this.

She was married at 16 and began having convulsions a few weeks later and for two years has had attacks frequently, probably one or more weekly. These attacks lasting from a few minutes to several hours.

Examination showed a small woman, rather thin, with active reflexes and some ill-defined hyperesthetic areas, whose hands and feet were constantly twitching and jerking. She had many complaints of pain of uncertain nature, mostly located in the abdomen and in the left parietal region. Over the right rectus is a large scar which she says is due to an operation for appendicitis, her description of her disease suggests that the operation was one of election rather than of necessity, at any rate she still has the vague abdominal symptoms of which she complained.

She had considerable abdominal pain and tenderness extending into the ovarian region. Pelvic examination showed hyper-sensitive genitals, with especial tenderness about the left ovary. Her reflexes were very active. The first hysterical manifestation occurred the second day after admission, she slipped from her chair without hurting herself, screamed, convulsed, pulled her hair, tried to beat her head on the floor, and was held still only by the combined effort of half a dozen women.

The next day I observed an attack, it began in the dining room where about 25 women were gathered. When first seen she was held by a number of women and was struggling violently. The other patients were sent from the room and she was permitted to roll about, she writhed about the floor, pulled her hair, bit her hands, got into the "arc de cercle" position and appeared to be in danger of injuring herself yet did herself no serious in-

jury. The inhalation of ammonia had a beneficial effect and the convulsion soon subsided.

These two attacks were all she had during her stay in the hospital. Suggestion and encouragement with appropriate medication appeared to control her major symptoms.

A little incident showing the abnormal mind is of interest. She was reported as eating little, and on inquiry she informed me that her appetite was very poor, that she was badly constipated, had a constant headache etc. this report was repeated for several days. Special diet with laxatives and cathartics were ordered but the reports remained the same until it occurred that this might be deception and privation practiced to elicit sympathy. On stopping personal inquiry and instructing the nurse not to give too much attention to the patient but to observe her closely, these troubles soon disappeared. After this she got along very much better and showed little evidence of hysteria. At Christmas time her husband came to visit her and she after changing her mind several times insisted on going home with him and so passed from our observation to an almost certain early relapse. This patient was naturally very unstable but some sexual irritation probably precipitated the attacks.

Some years ago I saw a case which this calls to mind, a young Jewish woman of good family, a nymphomaniac with hysteria, who from some abnormal mental state which included an intense desire for sympathy, on repeated occasions, inserted pins and small nails into the flesh of her hand so that it was kept in a state of irritation and suppuration for months and after much treatment finally required the extensive dissection under anesthesia before all the deep seated instruments of torture could be removed.

Case No. 5. A female epileptic who has been under State care for some years. Somewhat demented and ordinarily very quiet and phlegmatic. She had a peculiar attack last October. For a long time this woman has had so-called "cramping spells" with what appeared to be severe pain located in the ovarian region, however she always described the pain as being in her stomach or bowels. Her hysterical attack began with complaints of vomiting directly after eating and that her bowels did not move. Observation by her attendant proved the vomiting to be slight and probably induced; for the constipation she was given salts in moderate dosage. One night her abdomen was found somewhat distended but little was thought of it, the next morning she was in great distress with the abdomen greatly distended. The distention was almost equal to that of an advanced

pregnancy, the muscles were very rigid and severe intestinal obstruction seemed to be present. Rather frequent cramping spells occurred during which there was much complaint of pain, these spells often occurring directly after one entered the room, when she was observed without her knowledge she did not appear to be in much distress.

With these alarming physical findings and apparent pain there was almost no elevation of temperature and very little acceleration of the pulse. During the day numerous enemata were given, some containing magnesium sulphate and glycerine and mag. sulphate was also given by mouth, this treatment unloaded the bowels but did not materially change the abdominal findings. At night she was given morphine and rested well. The next morning her condition was not much changed. In all examinations it was noted that the distention increased under examination but that under firm pressure it could be reduced considerably. Auscultation showed an active peristalsis; there was practically no pain on palpation.

Dermographia was present and of a kind which I had never seen before, light tracing over the abdomen produced a slight blanching, then a slight reddening and finally a decided blanching which remained very distinct for a long time. On the third day the symptoms were similar but less marked. Some areas of hyperesthesia were found but they were ill-defined and not permanent. Eye symptoms could not be elicited but the mental condition of the patient is such that her answers are not reliable. This patient undoubtedly had some bowel disturbance and her frequent attacks of abdominal or pelvic pain had centered her attention upon her viscera. The peculiarity of her symptoms, together with the memory of several unfortunate cases of intestinal obstruction, caused me no little worry until it was pointed out to me that this was a functional case and so it proved to be.

These five cases of major hysteria occurring within a few months of each other, form one of those peculiar series which sometimes come to us all in our practice. Hysterical manifestations are common in some form in our work and suggest the probability of a closer relationship between hysteria and epilepsy that has been recognized. Minor hysteria is undoubtedly very common everywhere and major hysteria is, (though it is said to be uncommon in America) by no means rare. These cases show that it is not always recognized nor its convulsive form differentiated from epilepsy.

Its treatment I shall not attempt to discuss except in a brief outline:

- (1) Hysteria is a real disease and though often accompanied by willful deception, it deserves the consideration which would be given to any other mental or physical abnormality.
- (2) Hysterical patients should be separated from relatives and home surroundings, if possible, and so removed from unwholesome sympathy.
- (3) Suggestion in all its forms in an important therapeutic agent, wisely used, we can expect much from encouraging talk, positive statements in regard to cure, bitter medicine, painful or spectacular treatments etc. some say from hypnotism.
- (4) Lastly, good surroundings and good general health are important in the treatment and in preventing relapse in these unstable individuals.

#### DISCUSSION.

Dr. C. C. Goddard, of Leavenworth.—I was very glad to hear Dr. Hubbard's paper. It is about time the general profession woke up to the fact that hysteria is a disease, and making fun of it and trying to talk them out of it never succeeds. Drugs in my opinion are of very small value in hysteria, outside of some general tonics for the system. These cases, nearly all of them, you find are a class of neurotics; their troubles are just as real to them as though they actually happened, and the sooner you get their confidence and listen to their stories and make them believe you believe their stories, the quicker you will be able to do something for them, provided you get them away from their friends and home life, and then give them something to do, get the sub-conscious mind to work, fixed on the fact they are going to get well, and with patience and perseverance nineout of ten of them recover.

Dr. S. S. Glascock, of Kansas City.—I enjoyed the doctor's paper very much. This is a subject, which, of course, a man dealing in this class of cases naturally has a great interest in. The cases the doctor reported were very interesting cases. I remember a number of years ago in the clinics of Rush College I saw a case that had a temperature of 110, seemed to be able to bring that temperature up most any time. I have never seen anything approximate the temperature in that case. I had a case of a young lady 20 years old, she claimed she could not use herself at all, was paralyzed, was unable to talk,—in fact you could not get her to do anything; she had been in that condition ten or twelve days when I first saw her, and by the use of static electricity, and the suggestion that current would cause her to walk and speech would return, it returned very nicely. I remember another case, a man about 25 years of age, it took four people to hold him in bed. He was having convulsions, not like epilepsy, but something of that form. He would have them a number of times in 24 hours; he was taken to St. Margaret's hospital, but I suggested to the doctors that they might send the attendants home, and give him some medicine very unpleasant to take, and give it every hour, and as soon as the convulsions stopped the medicines should be discontinued, and when he started to have a convulsion I suggested to the sister she go away from him and let him fall out of bed, and he would get over close to the edge of the bed but would not fall out.



The doctor's suggestion that hysteria is a disease is certainly well borne out by everyone that has had occasion to observe these cases to any extent, and the idea suggested in his paper that it was necessary to get them away from their family and friends because there is a desire on their part to want to sympathize, and it is frequently difficult to overcome that disposition on the part of the friends to give them sympathy, and we must get them so that is taken away from them, and suggestion is one of the important treatments of this disease. You must suggest, get their minds imbued with the idea they are going to get better, and by that means you are able to accomplish the results you desire. The greatest trouble I have found, and I think that would be recognized by the doctor and the rest of the men that observe these things, is, what you are going to do with them after you get them straightened up. They go back to the same environment,—how are you going to keep them well when you get them well? We get them straightened up and send them home, and the same story is repeated, and it is with the greatest difficulty you can talk and impress upon the friends the absolute necessity of not giving the amount of sympathy to them that will cause the return of the disease. That is one of the troubles I have encountered.

Dr. G. B. McClellan, of Weir.—I have never personally seen a very high temperature but the doctor's suggestion in regard to extreme high temperature is borne out by very good authorities.

Dr. M. L. Perry, of Parsons.—I wish to emphasize the point brought out in the paper, also touched upon by doctors Goddard and Glascock,—that is the fact that we are prone to look upon these cases lightly and not consider they are very serious. These people are sick just the same as if they were constantly running to high temperature, and they deserve to be treated as sick people and not passed by with jests and looked upon as practicing deception. Many of them do, but the very fact shows they have an abnormal state of the nervous system, and abnormal craving for sympathy, and that of itself shows they are the subject of disease. We should relieve them of the wrong kind of sympathy, such as they get from people about the country who come and suggest remedies and talk about the symptoms to these people who are much inclined to talk along that line, but we should give them the right kind of sympathy, that of the professional man who knows what he is talking about. In regard to separating these people from their relatives, we cannot always send the subject of simple hysteria away to a sanatorium, although that probably is the best place, but we can separate them from the bad influence by taking occasion to talk with the family, explain the situation, and by keeping them at home, relieving them from the bad influences.

In regard to the matter of diagnosis, the doctor mentioned the fact that this disease is sometimes mistaken for epilepsy. At times the diagnosis is not easy. There are certain points which, if borne in mind and looked for closely will usually throw light upon the situation and tell us what they are. In the first place I would emphasize the importance of the sensory symptoms in hysteria. Practically all cases of major hysteria will show upon examination areas of insensibility, and often they can be accounted for in no other way than hysteria; they have no bearing on the anatomical relations. If we examine the field of vision we will often find it restricted. If it comes to actual convulsions we may have very severe convulsions. I have seen patients who had fifty or a hundred or two hundred convulsive attacks. The reflexes are often of value in determining what we have here. In hysteria the pupil is active; in epilepsy almost always this action is absent. Another point in the diagnosis of hysteria to be borne in mind is that this disease may produce very serious symptoms, as Dr. Glascock reported a case with temperature of 110. I have seen cases of simple hysteria run the pulse so it almost could not be counted, up close to 200, so we see this disease can produce very decided symptoms; and another point which has to be guarded against in the diagnosis of hysteria, and especially the difference between hysteria and epilepsy, we sometimes find cases of hysteria who really do not protect themselves, as is usually pointed out. I have

seen cases who would hammer themselves on the floor, and produce no serious results, but they would knock the skin off the head and face, so it is well to bear those points in mind.

Dr. L. H. Munn, of Topeka.—I have been interested in this story of hysteria. It occurs to me that the position of Galle (?) that with the light of more experience and better study there is pathology behind all these cases; that they are not neuroses in the sense of functional disturbances; they come under the class of neurasthenias. These two gentlemen are connected with an institution, they report a lot of cases that occur among epileptics that convince me more and more there is a pathology, and the further along you get and the more you study them, finally this pathology will be found. Some years ago I reported a traumatic case that the exciting cause was a railroad injury. She had proper material behind her and now by this suggestion she developed the full story, dementia, etc. Anaesthesia on one side and hyperaesthesia on the other. She would frequently not pass but one or two ounces of urine in 24 hours. I expressed the opinion that the woman would get well when she was separated. I watched her four years and have gone to see her, and she is still in about the same shape. These true hysterics don't get well. You send them away from the environment and give them a change of surroundings and they will improve but the minute they get back they will relapse, and finally, all of these are better in the insane asylum.

Dr. Jones of Lawrence.—There is one phase of these cases I think comes to all of us, and that is that many of these cases sooner or later look upon some deviation as being the cause of most of their ills. I think in most of those cases we have to be very careful what we promise the patient, and I think possibly most of us have found in those cases it is better to get the patient away from their environment than any direct surgical procedure. I have had several cases in the last year that have brought that idea home to me very acutely. It is not so much a matter of surgery as it is getting the patient's idea fixed on the fact she is going to get well. If you don't do that no matter how much surgery you are going to do, she is going to fall back into the same condition she was before.

Dr. Truehart, of Sterling.—To handle these cases psychologically it seems to me if we have our parents as well in hand as we have our patients it is hardly necessary to take them away from their environment. If you study psychology a little more I believe we will have less trouble. There is one phase of hysteria, or one diagnosis that probably should be brought out. Several years ago I had a case I supposed very pronounced hysteria, and treated it for about a week and it died, and it didn't die of the effects of drugs either. It was simply a case of inflammation of the brain, and many of these cases go to the insane asylum as being insane that is an extension of this same condition. It needs to be differentiated from hysteria. If we take the hysterical case and use these influences of suggestion referred to, and also use the same suggestion on the friends, we will usually control them pretty well without much trouble.

Dr. O. S. Hubbard, (Closing the discussion).—I don't know as there is much to say more than to emphasize again that hysteria is a real disease, and is very important, and is not recognized. These three cases which were supposed to be hysteria were diagnosed and sent to the State Hospital as cases of epilepsy, showing that the disease is not looked for, perhaps, as much as it should be; also it is very common everywhere. Probably any man who has anything of a practice sees many cases every year with symptoms which he may not recognize. Some years ago in my college days in the clinic of Dr. Church, in Chicago I saw case after case of hysteria, one after another, every day you could depend on them. It is undoubtedly true heredity is the great basis of hysteria, and the other day in reading over a copy of Dr. P——'s pamphlet on the Border Land I thought most of us had some of them. I wish again to emphasize the importance of a disease which can cause total blindness, total hemiplegia

and severe convulsions, as severe as you ever saw in epilepsy. As to pathology, some people say there is an actual disease in the cardiac cells, but we do know the brain controls the body almost absolutely, and this is a brain disease.



## ACUTE DILATATION OF THE STOMACH.

A case following an Operation for Suppurative Appendicitis.

DR. HUGH WILKINSON, Kansas City, Kansas.

Read Before the North-East Kansas Medical Society, Atchison, Oct. 8, 1908.

Acute dilatation of the stomach, up to the last few years, was seldom recognized. No doubt there were many cases heretofore but it has only been of late that enough attention has been called to the condition to make its recognition fairly easy and the cases consequently more numerous. The textbooks and encyclopedias of medicine and surgery "pass it up" lightly and it is only through medical literature in general that our knowledge has come. A thorough digest of all work done in this line, both clinical and experimental, is contained in "Annals of Surgery" for March and April 1908 and it is to that article by W. B. Laffer of Cleveland that I looked for nearly all the information I have on the subject. In the November 1907 number of the same journal J. C. Bloodgood of Baltimore reports several cases and discusses the subject thoroughly also. The disease comes on commonly after operations in the abdominal cavity but not always so. Laffer reports one of his cases as coming on after normal parturition. It resembles at first glance general peritonitis but on closer observation can usually be easily separated from that disease. The stomach within a few hours becomes immensely distended and filled with fluid and gas. A condition of great prostration, weakness and thirst takes place and in 63.5 % of reported cases death ensued.

The Pathology and Etiology are extremely misty as to facts although many ingenious experiments and theories have been advanced to explain the disease. The earlier writers attributed the disease to a prolapse of the small intestine into the small pelvis this causing tension of the mesentery and its enclosed structures. If we remember that this mesentery at its root crosses the transverse portion of the duodenum we can understand how sufficient tension might obstruct the duodenum and thus close the exit of the stomach. Rokitsansky as early as 1842 described a case and advanced this theory of its causation, many others later concurring with him. This seems at the present time



to be a very farfetched theory and other more reasonable ones have been advanced to refute it. It seems unreasonable to think that nature would leave such a flaw in her masterpiece and if so why the disease does not occur oftener. The most reasonable cause seems to be a palsy of the gastric nervous mechanism either peripheral or central and the most reliable observations and experiments uphold this theory. Braun and Sidel's experiments seem to be quite conclusive on the nervous origin of the disease.

There are only 217 cases reported in the literature but most of these have been discovered in the last few years. **The Diagnosis** of ones first case is usually not made before death but if we have the affection in mind the recognition of it is said to be quite easy. "The presence of distention, vomiting of large amounts of a greenish black fluid, no rise in temperature, rapid pulse, great thirst, little abdominal tenderness and increasing collapse" constitutes the clinical picture. The passage of the stomach tube removes the distention and clinches the diagnosis at the same time fulfilling the main indication for treatment.

The case I wish to report was a puzzle to me at the time but the diagnosis seems to be certain now and I wish to present a brief history of it and add a record of another case to the 217 now reported.

A married man 40 years of age was taken suddenly ill in Atlantic City N. J. with a severe pain all over the abdomen. He had had two similar attacks during the previous two years but neither of them was so severe as this one. He was nauseated but did not vomit to any extent. A physician relieved him with a hypodermic and he started west the next day. He came as far as Independence, Mo. where he went to a relatives home. He was intensely sick all the time he was on the train chilling at times and feverish but at no time did he remember the pain as being localized. He had several physicians in the course of the five weeks before I saw him all of whom advised surgical consultation which was always refused. All diagnosed the case as gall-bladder trouble.

Between five and six weeks after the onset, through the courtesy of Dr. J. F. Koogler of Paola, Kas. I was called to see him. I obtained the scant history just recited and found the patient in the following condition: He looked more dead than alive having had very little nourishment during the entire period of his illness. He was delirious in his manner and speech. His main complaint was an intense, agonizing pain over the lumbosacral region of the spine. He was not nauseated had not vomited



for some time, bowels moved with cathartics, passed urine normally and chemical and microscopical examination later showed the urine to be practically normal. He complained of hunger and starvation but would take very little food when offered. His pulse for several days previous to my first visit ranged from 95 to 112 and his temperature from normal to 102. Questioning him was very unsatisfactory owing to his mental condition.

**Physical Examination** showed him to be extremely emaciated and cachectic. He could flex and extend both limbs without much pain but any attempt to move him caused excruciating pain in the spinal region before mentioned. Locally there was no evidence of disease in that location. His abdomen was slightly distended and tender but there was absolutely no tumor or spot more tender than the rest, except possibly in the epigastrium. I could see no evidence whatever of disease about the liver. Deep pressure at McBurney's point gave me no more light. I was told that a prominent pathologist of Kansas City Mo. had examined the blood sometime previous and pronounced it normal. Conditions prevented that part of the examination at the time I saw him.

Two days later I found no improvement, greater weakness, the abdomen a little more distended and tender and on deep pressure over the base of the appendix it hurt a little worse than elsewhere. I could feel no tumor or marked rigidity. The spinal pain was worse if anything. Rectal examination revealed nothing of value.

From the history of the onset, the appearance of the patient, the point of exaggerated tenderness and the history of possible previous similar attacks I made a diagnosis of appendiceal abscess and advised operation at once giving a very grave prognosis either with or without operation but a better chance with one. It took them over two more days to decide.

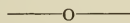
I operated Monday night by lamplight. An incision was made close out to the iliac spine, directly through the muscles and keeping well outside the cecum. The operation was transperitoneal and deep behind the cecum I burrowed into the abscess which was small but very foul. The general cavity had been walled off with pads before opening the abscess and after wiping it out a cigarette drain was inserted and the remainder of the incision rapidly closed. In spite of my misgivings the man held his own for three days. His pulse and temperature improved, the wound discharged freely, the abdomen remained soft and flat, the spinal pain left him, he urinated, he passed flatus freely

and took some nourishment. His bowels were thoroughly cleaned out by calomel and salines Thursday night and Friday. Friday his mental condition became worse his weakness greater and his abdomen distended somewhat. He did not complain of pain more than ordinary in such cases. He continued to pass flatus. His pulse became weaker and faster. Saturday morning these symptoms were all worse and in addition he began to vomit a blackish green fluid in small quantities and at frequent intervals. The abdominal distension was much greater but he continued to expel flatus from the rectum. He still did not complain of any marked amount of pain only great weakness.

I was called soon after noon to see him and found him in a marked state of collapse. The pulse was hardly perceptible, abdomen immensely distended and great weakness. The nurse told me he had vomited frequently the blackish fluid, and had been sinking steadily since I had seen him the day before. Soon after I arrived he asked to be turned on his side which the nurse did. As she did so the greenish black fluid ran from his mouth in a stream and with no straining. He died in that position and with the fluid running from him. I estimated the amount of fluid passed at this time to be at least 5 pints. There may have been more. It was quite liquid, rather foul but not fecal in odor.

I was mystified, as I said before, at the time of this man's death to know the exact cause of it (the immediate cause). If I had made a postmortem examination I am sure an absolute diagnosis could have been reached or had I used the stomach tube it might have been settled before death. In my own mind the passage of a tube on this man would only have hastened his death. The amount and character of fluid which ran from him at death was as conclusive to me as if I had put a tube in to get it.

So from the comparison of this clinical picture with the rather constant one of the disease under discussion the diagnosis seems to me to be fairly certain. I base my judgement on the following points: Great bodily weakness from the disease and starvation, the operation under general anaesthesia, collapse symptoms with great distention, weak and rapid pulse and open bowels, great thirst, and the vomiting of a rather characteristic fluid but especially do I lay stress on the amount and character of fluid passed from the stomach at death.



Diverticulum of the bladder, associated with cystitis, may produce symptoms resembling those of prostatic hypertrophy.--A. J. S.

## AN INIENCEPHALUS.

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E. T. SHELLY, M. D., Atchison, Kansas.

Read Before the North-East Kansas Medical Society, Oct. 8, 1908.

The word "Iniencephalus" is derived from two Greek words which mean, respectively, "nape of the neck" and "the brain", and it describes a fetal monster in which the center of interest lies in the nape of the neck where the deformity for which the name was coined, is found.

All examples of iniencephalus present three distinguishing characteristics, namely: imperfect formation of the occiput in the neighborhood of the foramen magnum, spina bifida of considerable extent, and retroflexion or bending backward of the spine.

A monster of this sort was born near Atchison about a year ago to parents of four other perfectly normal, healthy, living children. Nothing unusual occurred during the period of pregnancy excepting that the mother and her friends thought that her abdomen was considerably larger than had been the case in any of her previous pregnancies. She was 39 years of age, American and of good family history. The father is the same age as the mother, of splendid physique and apparently of excellent health. The plane of the face of the monster was at right angle to long axis of the body and there was no bony covering to the back of the head or to the spinal canal down to the lumbar vertebrae. The brain seemed to be enclosed in a translucent membranous sack, somewhat pear shaped, and it occupied what should have been the nape of the neck. The parents declined to permit an autopsy to be held, and consequently no detailed description of the monster can be given.

In my own practice I have met with two other similar cases. One of them was reported about twenty years ago in the University Medical Magazine of Philadelphia. The other occurred about fifteen years ago and was never reported. In the first and second cases the condition of the fetus was unsuspected before its birth, but in the last case I strongly suspected it because of the escape of an extraordinary amount of amniotic liquid, a condition which is almost invariably present in these cases. The first gush came while the patient was standing in the bath room, and seemed to be unusually profuse, but after she got into bed seven pints more of the escaping liquid was baled out with a mug, while the padding under her hips was thoroughly soaked as well. After this amniotic flood, digital examination

revealed a face presenting at a completely dilated os, and, while in this particular case it was an unnecessary procedure, the fetus was turned and a rapid breech delivery effected. It was a still birth.

Why does the fetus at times develop abnormally in this manner? In days of old, when supernaturalism was enlisted even more readily than at the present day to explain the appearance of unusual natural phenomena, monsters were ascribed to various gods, demons, evil spirits, and even to the moon and to the stars. Indeed monsters themselves may at times have been regarded as gods if we may credit the method of mythological interpretation instituted by Euhemerus, an ancient historian of Sicily, who



regarded all myths as "traditional accounts of real incidents in human history". By this method of interpretation the teretological appearance of the deities of Hellenic mythology can be explained, and the god Atlas may be Euhemerized into an iniencephalic monster.

In those ancient times natural causes were, however, also looked to, to explain the occurrence of fetal abnormalities some of these supposed causes being peculiar seminal or certain menstrual conditions, hybridity and maternal mental impressions. Of these ancient theories only one survives in our day, that of maternal mental impressions.



In regard to the relation which the impossible, anachronistic theory of maternal impressions held toward the particular case under consideration, it may be said that the mother had no thought of accounting for the deformity in that way. On the contrary, she declared that, as far as she could remember, her period of pregnancy had been quite uneventful, either physically—except as to the size of the abdomen—or psychically.

According to Ballantyne modern teratology seeks to explain the occurrence of iniencephaly by the "pressure theory", amniotic pressure being probably the active cause in all these cases. There is a stage during the third week of pregnancy in which there is a normal retroflexion of the embryo corresponding to that found in iniencephaly. Under ordinary circumstances, that embryonic retroflexion is quickly replaced by the attitude of the fourth week; but it is comparatively easy to understand how, if the bending of the spine be fixed, the iniencephalic state is produced. Let us suppose that uterine pressure, or more probably amniotic



pressure (due to non-development of the amnion), is brought to bear upon the retroflexed embryo: The spinal curves will be retained and exaggerated. As the head develops, the occipital part will find its expansion hindered by the adjacent spine, and the spine will have its closure posteriorly checked by the occipital part of the head, and in neither of these parts will ontogenesis

be able to pass on to completion. It is quite possible that retroflexion may be produced at other periods in embryonic and fetal life, and it may then be due to a short umbilical cord or to the entire absence of the cord, but the anomaly so caused will not be iniencephaly. . . It is the defective state of the occiput and the condition of spina bifida which, together with the retroflexion of the whole embryo, produces iniencephaly."

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## THE ROENTGEN RAY AS A DIAGNOSTIC AND THERAPEUTIC AID.

. EDWARD HOLMAN SKINNER, M. D., Kansas City, Mo.

Read Before the Kansas Medical Society, May 7, 1908.

The roentgen ray has now established itself as a reliable and valuable aid in the exact diagnosis of bone lesions, both traumatic and pathological. In fact, the bone condition that does not today have a roentgen record is a neglected case and sooner or later will entail discredit upon the physician who has failed to bring to his aid this valuable assistant in correct diagnosis. The public is rapidly coming to a knowledge of this exact adjunct and will reproach the physician who neglects its use. Do you think that the patient who has suffered a hip injury and who has not been subjected to a roentgen examination will forgive the physician when the case after a tardy convalescence proves that an early x-ray negative would have materially aided in establishing the diagnosis and made the outline of treatment simple? Will there be aught but a magnificent interrogation mark in the patient's mind as to the reason for this neglect?

Not only should we counsel ourselves in the use of the ray in all bone cases but also in the obscure kidney and bladder case where there is the bare possibility of stone. Shall we not afford the suspicious tubercular case and the obscure stomach condition this diagnostic aid? Is there any more painless and comfortable means of diagnosis, any more sure means of relieving the patient's anxiety, well-grounded or otherwise? Will not this vivid display of the true condition upon the roentgen negative persuade them to comply with the demands for treatment thus logically outlined?

Carl Beck, in a recent article laments "the widespread indifference still shown in the practical use of the roentgen ray." This remark anticipates a report of 217 cases of mal-union in fractures that failed to receive a roentgen examination though

treated by most excellent surgeons in a large city. He suggests the following axioms which I quote and commend most heartily: 1. No bone injury should be treated unless at least one reliable roentgen ray negative is taken. 2. The roentgen method in combination with the usual methods of examination determines the character of a suspected bone injury. 3rd. If there be no bone injury the usual treatment consists in massage followed by temporary immobilization. A movable (plaster paris) splint being recommended for the latter purpose. 4. If there be a fissure or fracture followed by no displacement, manipulation of the injured area must be avoided and immobilization in the most comfortable position applied. 5. If displacement, the fracture must be looked upon as a most important injury.

To these excellent axioms of Beck, I would add at least the one that after the fracture has been reduced and the splint has been applied, a roentgen negative should then be made through the dressings and splint (plaster paris preferred.) This examination would serve as a check and an absolute record of the proper treatment of the case, thus relieving the attending surgeon of malicious attacks and comforting the patient mentally.

The time is not far distant when a fracture (especially a suspicious fracture lesion) will not have received proper attention without an examination by the roentgen method. The satisfaction to the patient and the attending surgeon cannot be overestimated.

I shall not take more of your valuable time in the discussion of the diagnostic value of the ray in bone lesions, other than to discuss informally some of the steroptic lantern slides that vividly tell their own story.

The roentgen method of diagnosis in kidney lesions is now upon a safe basis. The roentgen is able with the improved tube and apparatus to turn out negatives than are above conjecture in diagnosis. When the negative portrays the transverse process and the psoas muscle one may be fairly sure that a stone will present a demonstrable shadow. The roentgen negative is essentially a record of the densities of the various tissues interposed between the roentgen tube and the sensitive plate. Therefore we may be fairly sure of our roentgen diagnosis when the kidney negative possesses the former qualifications, if the patient has been properly prepared by an intestinal cleansing to avoid a fogging of the negative by collections of air and faecal accumulations.

Kidney examinations by the roentgen method is necessarily

without the province of those who do not possess x-ray apparatus that is capable of delicate work. There are many errors to be avoided in kidney examinations that are of interest only to roentgenologists and I shall not burden you with a discussion of these. I shall however present to you a few kidney negatives for your inspection.

The roentgen ray has had more favorable patronage in the continental hospitals than in the private laboratories of America. This is due no doubt to the expense of this class of roentgen work. American hospitals and laboratories have failed to appropriate sufficient funds for this work. The apparatus for radiographic and radiosopic stomach and chest work should approximate the following principles to insure efficiency and protection to the patient and operator. First, and foremost, the protection of the operator and of the patient. Second, a position of ease and comfort for the patient. Third, a proper adjustment of the tube to the patient, that the maximum amount of parallel rays may be used in the examination. With an appreciation of these principles, I have devised an apparatus after the plan of Keinbock and Groedel, two German roentgenologists. In a recent number of the Interstate Medical Journal, I reviewed this field of roentgenology and would direct those interested to this article. Pfahler of Philadelphia has experimented extensively in the use of bismuth suspension emulsions and I believe has practically demonstrated the advantage of kephir as an emulsion media. When this emulsion is introduced into the stomach and intestinal tract we are able to reproduce the opaque shadow of the visceral outlines upon the roentgen negative. The diagnosis of a gastropotosis or enteroptosis therefore becomes more or less of a simple matter. I have as yet to encounter any ill effects from the use of one to two ounces of bismuth in a roentgen examination. In a recent review of the literature upon abdominal diagnosis by the roentgen method, Soper of St. Louis, made the following summary: 1. The diagnosis of the relationship of the stomach to the abdominal wall, the diaphragm, the large intestine, liver etc. 2. The study of the effects of massage, electricity and other stimuli upon peristalsis. 3. The motility, i. e., the time in which foods leave the stomach, has been studied by Jolasse and others. Jolasse's results were, briefly, that after the administration of the bismuth meal; normally no shadow should be visible after three hours in males and four hours in females. 4. The differentiation between intra and extra ventricular tumors. It can be readily ascertained whether or not palpable epigastric tumors are connected with the stomach.



5. The differential diagnosis between extra and intra ventricular localization of other clinical symptoms. For example, it is of value to know whether or not an area of localized pain or tenderness to pressure, is situated in the stomach. 6. The diagnosis of growths encroaching upon the cavity of the stomach; this refers particularly to carcinoma. Should the growth project into the large air bubble or magenblase which is always visible in the cardiac portion of the stomach, it becomes distinctly outlined. In growths near the pylorus, the loss of peristalsis is a valuable sign of infiltration of the stomach wall. Anti-peristalsis means pyloric obstruction. Projection of the growth causing irregularities in the cavity are also of value. 7. The judgement of the size, form and position of the stomach. This is studied chiefly with the patient in the erect position. Rieder, Groedel and others maintain that the fish-hook or siphon form of stomach outline is normal. Holzhecht found this form in 80 % of the adults he examined.

The investigation of the abdomen with the ray is a comparatively new study and there is much as yet to be brought to our attention. The diagnosis of thoracic lesions yeilds a fertile field for the roentgenologist also. The early diagnosis of tuberculosis is accomplished in the hands of careful roentgen workers. This work demands a powerful apparatus and excellent tubes to produce negatives with a very short exposure. A negative of the thorax would neccessarily be blurred if it was taken during respiration. The value of the x-ray negative or the radiosopic examination is easily demonstrated in the localization and knowledge of the extent of a solidified area, cavities, atelectasis, abcess, gangrene and foreign bodies.

The past year has been very interesting to the conscientious roentgenologist who is also applying the roentgen ray for its therapeutic value. The early claims of nearly every owner of an x-ray tube have been tempered. I believe that the American Roentgen Ray society is responsible for the new and sane estimate of the value of the ray therapeutically. The use of the Ray therapeutically does not consist in merely adjusting the tube to the treatment area. The roentgen therapist must pay proper attention to the protection of the patient and especial attention to his own protection if he desires to live his expectancy, possess a presentable pair of hands and avoid sterility and damage to his retina. The early investigators of the x-ray have been martyrs and are now paying the penalty. And so I would issue this warning to all who are doing any x-ray work whatever. Protect your-

self throughly and your patient properly against the insidious action of the continued use of the x-ray. The subject of roentgen ray sterility has taken the place in roentgen discussion that the x-ray burn held a few, yes a very few years ago. And as to-day it is considered very bad form fo a roentgen therapist to produce a burn, so, I predict, that the sterile x-ray operator will be relegated to the past in a short time. The insidious and accumulative action of the x-ray is responsible for the many new phenomena that arise with its use. While the means of protection is most eminently interesting to the roentgenologist, it is well that the surgeons and internists referring cases to roentgenologists be assured of the possibilities that they may rightly inform their patients who may inquire regarding any such danger from exposures. The happy feature of the subject is the fact that there is absolutely no danger to the patient submitting himself to short exposures for roentgen negatives or flourescopic examinations. Likewise there is no danger of burning the patient. In the therapeutic treatments there is no danger of sterility or burning where the tube is encased in a covering opaque to the ray and this protecting media diaphragmed to the exact field of the application. Such protecting devices together with proper filters of leather, silver, aluminum and gauze guard the patient and aid in attacking the diseased area with the proper quality of x-ray. The protection of the roentgenologist becomes a more vital and difficult proposition because he is constantly with the ray. To obviate this danger, I have devised a large protecting lead shield and switch-board that satisfactorily protects. The operator places the shield and switch-board at any place in the room that is convenient to his work. The switches are all behind the lead shield and he can view his tube through the lead glass window of the shield doubly protecting his eyes with lead glass spectacles.

In outlining the use of the ray therapeutically, I would divide the field in to its application to superficial lesion of the skin and to the deeper lesions of the glands and blood-forming tissues. The skin diseases to respond to the ray are preeminently the old acne vulgaris and the old case of psoriasis. Epithelioma is a condition in which the use of the ray is established. Carcinoma of the breast should be submitted to the ray after a careful surgical removal as extensive as possible. The results of the use of the ray in thyroid enlargements justify its use. Especially is this true in exophthalmic goitre, when we will usually be able to relieve the condition entirely. In the cystic and fibroid forms the ray

will aid in reducing the nervous symptoms and the rapidity of the heart action although we cannot expect to reduce the size of the gland to normal. The most brilliant results of x-ray therapy are exhibited in the treatment of leukemia. The literature on this subject during the past year has been gratifying. The use of the x-ray indiscriminately in skin lesions and cancer is to be deplored. Its field is being defined and its use should be confined to specialists who are familiar with its use.

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## INJURIES TO AN EYE.

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W. H. GRAVES, M. D., Pittsburg, Kansas.

Read Before the Crawford County Medical Society, September, 1908.

In considering the subject of any form of an injury to an eye, I think for all practical purposes, injuries to an eye may be divided into superficial and deep. All injuries which do not involve the interior of the eye I think may be classed, for working purposes, as superficial. Those injuries which pierce the interior of the eye, or involve the deeper structure of an eye, such as the lense, can be classed as deep injuries.

It is my purpose to consider only a few forms of injuries, especially those which are most destructive to vision and the integrity of the eye-ball.

When an eye has been injured, whether the injury has been superficial or deep, I consider the vision of the eye always at stake because of the possibility of infection. I think it has been the experience of every physician to have seen an eye lost as the result of a very superficial injury, because of neglect and disregard for antisepsis.

Of the superficial injuries, I shall mention only the foreign body and the due respect which should be paid to it when lodged in the layers of the cornea.

The knife for removing a foreign body, should be stiff and should have a very fine point, which will cause the least possible destruction to the uninvolved corneal tissue. This is a point always worth remembering in removing a foreign body; for the more corneal tissue removed, the greater is the area for future infection, and after the local anesthetic has worn off, the more likely the patient to suffer pain and the congestion which was present, to remain. It is always best when much corneal tissue has been destroyed, to bandage the eye after the conjunctival sac has been thoroughly cleaned; first, to prevent infection. Second

because it keeps the air and light from the raw corneal surface, thus preventing pain. When these two points have been successfully combatted any superficial injury will usually heal readily, provided, that the wound is not infected at the time of the injury, or short time after. If infection does occur, the treatment then resolves itself into that for an ulcer of the cornea; which is cleanliness of the eye, combatting the infection with antiseptics and caring for the iris to prevent adhesions.

Perhaps the next injury most commonly met, and which is always very destructive to vision, is the piercing of the cornea by a foreign body, which in nearly every case, wounds the crystalline lense. At this point, I wish to lay special stress upon the first care of an eye which has received a deep injury, because if the foreign body did not carry infection with it, the way is open for infection to easily enter; so the necessity for great caution. Oftentimes the physician who first sees the case does not care to watch the eye through to recovery and it is necessary to give the eye a temporary dressing. The temporary dressing should consist in cleaning the eye-lash and eye-brow with freshly boiled water, and if the physician thinks best, flushing the conjunctival sac with sterile water, followed by sterile gauze dressing. When the proper treatment is commenced, and it should, if possible, follow shortly, no solution should be instilled into an eye with a deep injury except those in which the solvent has been freshly distilled water. It has also been my custom to know that my bottles, as well as the corks, have been freshly boiled if it is necessary for the patient to use any medicine, which is always the case if the patient cannot go to a hospital.

When the cornea has been pierced, the anterior chamber is immediately emptied of its aqueous, thus allowing the iris and lense to bulge forward against the posterior surface of the cornea. Often, with the rush of aqueous humor through the wound, the iris is carried into the wound where it often becomes incarcerated. In a short time after the eye has received this form of injury, the crystalline lense, if it has been pierced, commences to swell and oftentimes very rapidly. Now when this form of an injury has occurred, as before mentioned, the first care on the part of the physician is to put the eye-lids, cilia, conjunctival sac and the lips of the wound in as nearly an aseptic condition as possible.

The next step is the care of the iris. In my paper on iritis, in the July issue of the Kansas State Medical Journal, I refer to a case of trauma of the eye where the lense was injured. I did not see the case until sometime after the injury. In this case, the



iris had become adhered in several places, to the lense. One of the first steps in caring for a deep injury of this nature, is to produce and maintain a good, free dilatation of the iris with a cycloplegic.

By doing this, we have accomplished several things which are important. First, we have prevented, as far as it is possible, adhesions occurring between the swollen lense substance and the iris. Second, by drawing the iris back, we have made more room for the swollen lense. Third, when these two factors have been accomplished the pain is at once modified to a great extent. The complications of this class of injury are two: one occurring at the time of injury and which should also receive immediate attention. When the foreign body pierces the cornea, the aqueous humor rushes out and oftentimes carries with it, through the corneal wound, a portion of the iris, which if not given almost immediate attention, will become adhered to the cornea at this point, and will also, at the acute stage of the injury, be a factor in producing pain.

If this complication has occurred, the portion of the iris protruding through the cornea should be caught with iris forceps, and if possible, pulled still further through the corneal wound and cut off. In this way, the iris has been freed from its entanglement and in many instances will resume its proper position. Oftentimes, such good results cannot be gotten possibly, because of delay, yet that portion of the iris protruding through the corneal wound should be removed because it has become strangulated, and if removed, will aid in reducing pain, also the healing of the corneal wound will take place sooner.

The second complication which may arise is, the tension of the eye may become greatly increased, due to the rapid swelling of the lens; when this condition occurs the pain is intense, and if the tension is not relieved, the eye will soon be in a state of secondary glaucoma. I believe the best method to pursue now is to make an incision in the cornea very similar to the cataract incision, and express from the anterior chamber as much as possible of the lense substance. Oftentimes the entire lense substance can be removed. When it becomes necessary to remove the lense substance, we not only relieve our patient, but probably give him useful vision.

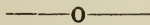
Injuries to the ciliary body should be handled in exactly the same manner, except that the uninjured eye should be constantly watched for any sympathetic irritation, and if this appears, the injured eye should be enucleated. I believe that when an

injury to the ciliary body has been received, the patient should be under constant daily observation. If, when the ciliary body has been injured, all useful vision has also been destroyed, I think it is better to remove the eye at once, because there is nothing gained by keeping the stump, and there is no doubt that removing an eye of this nature will protect the other eye from sympathetic inflammation.

After an injury to the ciliary body, oftentimes the eye-ball atrophies and will occasionally become inflamed and tender to the touch. Sometimes in spite of every thing that can be done, the eye will never become quiet. Here in both these cases, the eye should be removed.

Another form of injury involving the deep structures of an eye, is that of a blow or an injury from a concussion which may oftentimes produce a traumatic cataract and the exterior of the globe is in no way injured. If one can see the injured eye immediately, the anterior chamber is usually found to be so filled with blood that it is impossible to obtain a view of the interior. When a condition of this nature is present, the physician should be guarded in his prognosis, for as is sometimes the case, a cataractous condition of the lense occurs. This form of an injury that I described while in no way injuring the exterior of the eye may have caused a rupture in the lense capsule, which will soon be followed by the lense taking on a cataractous condition. To illustrate, we will cite a case:—Patient E., age 5 years; was struck in right eye with a spring. I saw case soon after injury. Found a slight cut in upper lid; lid somewhat swollen. Inspection of eye revealed anterior chamber to be filled with blood. With the exception of the eye-ball being somewhat congested, there were no visible signs of any penetrating injury. I immediately commenced the use of atropine and heat, and also moved the bowels. In a very short time the blood had disappeared from the anterior chamber. The patient came to me February 26, 1908, and on March 15, 1908, a distinct haziness of the lense could be made out. I kept patient under observation and in a comparatively short time patient had only 20-200 vision.

As I mentioned in the beginning, I have not attempted to give every variety of an injury that may occur to an eye, but only those that are most destructive to vision and that we meet in our daily work.



A feeling of discomfort in the mouth while eating may be the first signs of a calculus in one of the salivary ducts.—Am. Jour. Sur.

## OSTEOPATHY AND THE PUBLIC PRESS.

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By FRANK A. CARMICHAEL, M. D. Goodland, Kansas.

The influence of the lay press in propogating and fostering popular fads and frauds is strikingly illustrated in the September issue of the *Cosmopolitan*, one of the most widely read magazines of the lighter class, under the caption "What is Osteopathy?" by Belle Case Harrington.

In the September and again in the October number of the *Metropolitan* magazine there also appears lengthy and profusely illustrated articles (advertisements) by E. M. Downing relative to the same subject.

A careful study of these articles will convince any one that we are face to face with an entirely new departure in the art of advertising cunningly devised to reach the great mass of reading people through the medium of cleverly written advertisements that are so artistic in their composition and so elaborate in detail as to be allowed space in the general column of such magazines as the *Metropolitan* and *Cosmopolitan*.

To do these papers justice I do not believe they realize the tremendous impetus given to quackery by such advertising through such a medium, nor how powerless they themselves should they so elect, would be to undo the evil that has been wrought by these plausibly written endorsements of the osteopathic fake which will reach thousands of uniformed readers and cause hundreds of suffering victims to be fleeced by recourse to this system of charlatanism. To the physician and to the educated laity, the article is merely humorous. To bizarre logic (if it might be dignified by such a title), the painstaking though incongruous grouping of scientific phrases and the exploitation of the numerous cures (?) designated as "Tragic" "Marvelous" "Dramatic" etc, which abound in the course of the advertisement savor too strongly of the extravagant claims of the nostrum vender to merit consideration except in so far as they are amusing in their absurdity.

From a standpoint of advertising these articles are certainly strategic and from the careless manner of handling scientific facts they challenge the attention. It is the great body of reading people who read without analyzing and absorb without question the pabulum that is handed out to them by the public press that will be injured and mislead by such cunningly disguised advocacy of Charlatanic methods. It is both humiliating and discouraging to the medical profession and press to see the leading lay journals

lend themselves so readily to the exploitation of a system so far removed from proven and accepted scientific fact, and while both the medical profession and the press are carrying on an active campaign of public education in hygiene, sanitation and preventive medicine under great difficulties and at considerable expense their efforts are thwarted and baffled by the cooperation of the lay press with the various cults and isms to muddle and befog the intelligence of the people.

The article in question only tend to prove that this cult is as resourceful as they are unscrupulous and ignorant. That they are not amendable to punishment for their many flagrant violations is shown by the repeated failure of those injured by their gross ignorance to obtain redress through the courts.

The decision of the Kansas City Court of Appeals in the case of Robertson vs. Wenger, in which the plaintiff was treated for an alleged dislocation of the hip when no such dislocation existed and in the course of treatment sustained a double fracture of the femur, which under the care of the osteopath united with deformity and shortening, judgement was rendered in favor of the defendant because "He was not charged with being unskillful or lacking in professional skill." According to this decision if a man is attacked by a professional prize fighter and has a few ribs torn out and his solar plexus knocked into a cocked hat he could not obtain redress unless he was observant enough during the melee to testify that his assailant was lacking in (pugilistic) skill, in his manner of administering treatment.

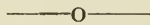
It seems to me that an action brought to recover damages for for such injuries as were sustained in this case, would be more fittingly classed as cases of assault than as those of malpractice.

The blatancy of the osteopath in asserting the curative value of his methods shows a firm conviction that you have only to reiterate a statement sufficiently often to have it accepted by the public as a fact. They are fully aware that it pays to advertise and being hampered by no code of ethics and being adepts in the art from their previous years of gulling the afflicted they have become aggressive advertisers.

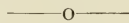
The medical profession has been inclined to utterly ignore this class of irregulars deeming them unworthy of consideration, yet while we are spending time and money educating the laity in how to escape disease, in securing wholesome legislation relative to public sanitation and hygiene in securing pure food and drug laws and suppressing the sale of worthless and harmful nostrums, in seeking to elevate the standard of medical education for the ben-



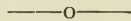
efit of the public and profession alike, would it not be well to institute measures looking toward the protection of the public from this class of charlatans, who practice here as osteopaths, there as magnetic healers and other places as chiropractics. To the shame of the medical profession it may be said that they are in a measure responsible for this evil. By their indifference they have permitted it to thrive off the credulity of an afflicted public without seeking to secure legislation to check its progress, while the so called osteopath, by means of concerted action and by the aid of funds filched from deluded followers have been able to maintain a lobby in the legislatures of various states to secure the enactment of laws favorable to their interests.



**Hydrotheraphy in Scarlatina.**—D. S. Hanson, Cleveland (Journal A. M. A., Oct 17), advocates the use of the tub bath at 90 F. early in the treatment of scarlatina, especially the severe toxic cases, for the nervous symptoms, although in patients with high temperature in whom severe nervous symptoms are lacking, the benefits are nearly as marked. He gives the bath for from five to ten minutes, using, at the same time, gentle friction to the body surface. The bath is repeated as often as necessary to control symptoms and temperature. He has used it this way sometimes as often as every two or four hours for three or four days. If a bath tub is at hand the patient may be lowered into it, lying on a sheet, but in his cases an ordinary wash tub was employed. In order that the thermogenic process may not be interfered with seriously, it is necessary that the body be protected after coming out of the bath. Several cases are reported.



Polypi in the ear (as in the nose) indicate diseased bone conditions. Removal of the polyp does not prevent recurrence; removal of the diseased bone does.—Am. Jour. Surgery.



**Antimeningitis Serum.**—F. J. Sladen, Baltimore, (Journal A. M. A., October 17), reports the results of the use of Flexner's serum in twenty-one cases of cerebrospinal meningitis in the Johns Hopkins Hospital. From their experience they give their impressions substantially as follows: All cases of meningitis in which the meningococcus is suspected should be treated by lumbar puncture and serum injection as soon as possible. The serum does no harm if the case is not meningococcal, and may do good. The course of the disease is changed by the serum—the long-drawn-out cases are not seen, and the terrible sequelæ are

# THE JOURNAL OF THE Kansas Medical Society.

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**JAMES W. MAY,** - - - - **EDITOR.**

**J. E. SAWTELL,** { ASSOCIATE EDITORS } **CHAS. S. HUFFMAN.**

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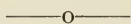
## EDITORIAL

It is the imperative duty of the physician to notify the parents of children who are known to be suffering with adenoids, of the great danger to permanent loss of hearing and facial deformity unless an early operation is performed. That the operation in competent hands in almost without danger and the good effects are permanent. When mouth breathing is first noticed it is time for decided action for, in a large percentage of cases adenoids will be found to be the causative factor.

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One of the most idiotic things for a supposedly sane person to do, is to calmly inform a patient who has been bitten that the animal is rabid and rabies will probably develop. In the average patient this suggestion will produce a pseudo-hydrophobia which may end in death. The wise thing to do after the patient has had the wounds cauterized, if rabies is suspected, is to at once send them to the Pasteur Institute there to receive immunizing treatment. The patient in this event will not feel alarmed or have a mental breakdown. If we must use suggestion in treatment of disease why not use suggestion to prevent them.

The Ochsner Treatment for Appendicitis will be the innocent cause for many physicians treating in place of operating upon cases of appendicitis. The author of the paper does not desire to convey the impression that an early operation is not desirable but expressly states that the best procedure is immediate operation except when the case is seen late in the disease when his starvation treatment is advisable. The physicians who have held out against operation heretofore will now conjure themselves into the belief that they now have a valid argument to support their view.

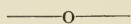


The examination of school children at stated intervals by a board of physicians is absolutely necessary for the preservation of health. It is a fact that in New York City statistics have been shown that 65 per cent of the school children are suffering from defective eye sight, hearing, etc. Again there can be no doubt that a great many are suffering from tuberculosis, and other infectious and contagious diseases, and by coming in daily contact with healthy children are sure to infect some of them. In some of the schools medical inspection is carried out but it is not a common practice to be sure. We must have laws to correct this evil, which will allow children to go to the public schools with some degree of protection and also as a means of enlightenment for the parents of the children who are suffering from disease so that they can receive the needed care and attention.

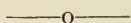


## CLINICAL NOTES

A small, hard, irregularly nodular scalp tumor is very likely an endothelioma. A little section should be removed under local anesthesia for microscopical examination. If the diagnosis is corroborated, radical removal is necessary.—Am. Journal Sur.



Carbolic Acid is a good agent with which to cauterize a corneal ulcer. It should be used 95 per cent, on a small tooth pick swab the excess of which has been removed by shaking. A swab previously dipped in alcohol should be in readiness to be used if the acid comes in contact with healthy corneal tissue.



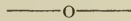
**For Gastroenteritis**—The following is recommended to be given in cachets twice daily with meals:

℞	Purified ox gall.....	gr. viiss;
	Magnesium hydroxide.....	gr. viiss.

M.

—N. Y. Medical Journal.

rare. The rapidity of the disappearance of the symptoms and signs with the use of the serum suggests an antitoxic property; the positive chemotaxis for polymorphonuclear leucocytes, and the promoted phagocytosis are the most definite and constant features; finally the reduction in number of the diplococci, the change in the straining properties, and the loss of viability, speak for a bactericidal power, although it is a question whether this may not be explained by phagocytosis. Three of their twenty-one patients died, a mortality of 14 per cent, as compared with 64 per cent in patients treated without the serum in previous years. One case of the three was a fulminant case, one was complicated with bronchopneumonia of both lungs when received, and the third patient received his first injection on the fourteenth day of the disease, when he was unconscious, in convulsions, and practically in extremis. Sladen and Parker believe that the serum injections should be made daily until there is a drop in temperature and disappearance of symptoms, indicating arrest; and that it should be renewed at any sign of a flare-up.



**Perforative Appendicitis in Pregnancy.**—E. A. Babler, St. Louis (Journal A. M. A., October 17), reports a case of perforative appendicitis complicating pregnancy, successfully operated on, and remarks that this is one of the most serious and fortunately also one of the most infrequent complications that may occur in this condition. He is inclined to think, however, that appendicitis occurs with greater frequency than the tabulated cases would indicate, and that as the accident of perforation fails to occur, they are not always recognized. He does not believe, however, that pregnancy predisposes to appendicitis, though it may precipitate an attack in certain chronic cases. Clinically, it does not differ from that occurring in the non-pregnant, and the diagnosis is not usually difficult. As Webster has said, we must bear in mind the possibility of ureteritis and pyelitis. The mortality is due largely to delay, and early efficient surgical treatment is imperative. If perforation has occurred, and if the abscess is localized, incision and free drainage are indicated. It is better to evacuate an appendiceal abscess before emptying the uterus, since it eliminates the possibility of flooding the free peritoneal cavity with pus. If general peritonitis is present, incision and drainage without disturbing gestation are indicated, provided the pregnancy has not gone beyond the fourth or fifth month. In cases near the end of pregnancy, forced labor is indicated.



**Furunculosis.**—In the case of a man aged thirty-seven, afflicted with crops of furuncles making their appearance on arms, neck, and body about every two weeks, Shoemaker (**Medical Bulletin**, April, 1908) prescribed rest for a week and an absolute milk diet, beginning the treatment with a thorough purging by means of calomel, gr. ij, in divided doses, powder form, dry, on the tongue every half hour, followed by a tablespoonful of magnesium sulphate in the morning. The following was then ordered to be taken regularly as prescribed:

R Extract of nux vomica .....	gr. vi;
Arsenic trioxide.....	gr. xx;
Calcium sulphide.....	gr. xx;
Quinine bisulphate.....	gr. xIv;
Extract of gentian.....	oz.

M. ft. capsulæ xxx.

Sig.: One capsule after each meal and at bedtime.

—N. Y. Med. Journal.

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**Gonococcus Vaccine.**—N. E. Aronstam, Detroit, Mich. (Journal A. M. A., October 24), finds that the gonococcus vaccine acts beneficially in acute cases of gonorrhea and the time required to cure the disease does not exceed four weeks. It is also useful and may be considered curative in some of the complications, such as epididymitis, Cowperitis, acute prostatitis, gonorrheal adenitis, enlargement of lymph channels on the dorsum penis, and in posthitis of the same origin. He has also used it lately with success in gonorrheal iritis. No other treatment, systemic or local, is necessary. In chronic cases it is inert and acts indifferently, owing to the mixed infection in these cases, and the conjoined use of other bacterins suggests itself. It is a valuable diagnostic agent, bringing to light latent or dormant conditions and showing whether a given case has actually been cured, and especially important point for sociologic reasons. In dormant gonococcic arthritis it will bring about a recrudescence of the disease. It materially shortens the duration of this complication and brings about a speedy cure. No exact rule can be given as regards dosage and intervals of administration; each case must be treated individually. Aronstam considers that the future possibilities of gonococcic vaccine and opsonotherapy in general are unlimited. Its bearing on prophylaxis in this disease, which must be recognized as a systemic and not a local infection, must be considered.

**For Dysenteric Diarrhœa.**—The following is prescribed by Pouchet (Journal de medecine de Paris):

R̄ Bismuth salicylate .....	℥iii;
Camphorated tincture of opium.....	℥iv;
Glycerine.....	℥iss.
Peppermint water.....	℥iv.

M. et sig.: Tablespoonful every hour.

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## NEWS NOTES

**Correction**—In Dr. J. S. Wevers discussion of Dr. M. T. Sudlers article on Local Anaesthesia in the Oct. issue he is quoted wrongly. In place of using bichloride 1 to 1000 it was adrenalin chloride 1 to 1000.

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The Wyandotte County Medical Society is in the midst of its winter work. Meetings are held weekly and an excellent program has been arranged. The meeting place has been changed from the Council Chambers to the Mercantile Club rooms and the time from Monday to Tuesday evening.

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The North-east Kansas Medical Society held its semi-annual meeting at Atchison Oct. 8th. The meeting was a successful one in every particular many valuable papers being read. The society was entertained with a banquet at the Byram Hotel. The society will hold its next meeting at Topeka, February 1909.

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The South-east Kansas Medical Society held its semi-annual meeting at Independence Oct. 13th. The attendance was good and the papers elicited lively discussion. The society was royally entertained by the Montgomery County Medical Society with an automobile ride and banquet. The next meeting will be held at Parsons in April 1909.

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At the last meeting of the Mississippi Valley Medical Association the following officers were elected for the ensuing year:

Drs. J. A. Witherspoon, Nashville, Tenn., President; Louis Frank, Louisville, Ky., First Vice-President; Albert E. Sterne, Indianapolis, Ind., Second Vice-President; S. C. Stanton, Chicago, Ill., Treasurer, and Henry Enos Tuley, Louisville, Ky., Secretary.

The next annual meeting will be held in St. Louis, Mo., October 1909.

The South-west Medical Association comprising the states of Kansas, Missouri, Arkansas, Oklahoma and Texas held its annual meeting in Kansas City, Mo., Oct. 19, 20, 21st. The society was well entertained by the physicians of Kansas City with a banquet for the ladies and their escorts, an automobile ride and luncheon for the ladies, and a smoker for the doctors. The program was a good one and well carried out. Dr. Jabez Jackson of Kansas City, Mo., was elected president and Dr. F. H. Clark of El Reno was re-elected Sec'y. The society will meet next year at San Antonio, Texas in 1909.

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Correction.—In the closing discussion of his paper on Opsonins and Agglutinins in the September issue, Dr. L. R. Sellers was quoted as saying "Snake posion is an antitoxin and further on "Here comes France—they say quinine is a parasite." This is what he said. The serium used against snake venom is not an opsonin, but an antitoxin. Nothing was said about France, but he said quinine is a germicide and probably destroys other than malarial germs. He also referred to the gonococci found in the bodies of the dead leucocytes, as an example of phagocytosis.

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The Western Kansas and Decatur and Norton County Medical Societies held their annual meeting at Selden, Kansas, Oct. 28th. The following program was given:

Address, Dr. C. C. Goddard, President State Medical Society. Paper. "Cancer of Stomach" Dr. C. G. Brethouwer, Norton, discussion opened by Dr. E. J. Beckner. Paper. "Tuberculosis" Dr. I. B. Parker, Hill City, discussion opened by Dr. H. O. Hardesty. Paper. "The Common Diseases of the Eye", Dr. C. W. Cole, Norton, discussion, Dr. A. C. Gullick. Clinic and clinical reports under the direction of Drs. Kenney and Beckner. Address on Surgery, Dr. J. G. Sheldon, Kansas City. Paper. "Hyperchlorhydria, Its Diagnosis and treatment, Dr. F. H. Smith, Goodland, discussion opened by Dr. Standard. Paper. "The Thymus Gland". Some remarks on its relation to Other Morbid States, Dr. F. A. Carmichael, Goodland, discussion opened by Dr. C. S. Kenney.

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For Sale.—Very cheap for cash, a doctors office in Lawrence. To be sold on account of death. Address J. R. Leonard, 646 Kentucky St., Lawrence, Kansas.

# THE JOURNAL OF THE Kansas Medical Society.

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## DIETO-THERAPY OF ACUTE FEVERS.

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By Dr. C. F. MENNINGER, Topeka, Kansas.

Read before the Kansas Medical Society at Iola, May 7, 1908.

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The endeavor to bring about the healing of the sick person by means of appropriate change of nourishment is called dieto-therapy.

Scientists have gradually worked out a science of nutrition during the past fifty years but it is only within the past ten years that the art of applying appropriate nourishment for the cure of the sick has taken form.

It can safely be said that the Science of Nutrition began with V. Liebig and the Art of Dieto-therapy with V. Leyden.

V. Liebig, the father of the modern methods of organic analysis, gave to the world a large amount of the knowledge it possesses today concerning the chemistry of the carbon compounds, the constitution of foods, of urine, of feces and of tissues. He applied to the problems of biology the mental wealth of the newer chemistry which he himself was creating. In 1842 he suggested that the nitrogen of the urine might be made a measure of the protein destruction in the body. Thus began the science of nutrition. That torch of knowledge which he so marvelously developed was next intrusted to the hands of Carl von Voit, who after years of the most painstaking investigations and profound studies, laid the chief generalizations of this new science.

The endeavor to cure the sick by proper changes of diet has always existed and its history is interwoven with the history of mankind. The sacred writings of the Egyptians and of the Hebrews give evidence of this fact. It is just as deeply rooted in the consciousness of man that food contains healing powers as that it



may be the cause of weakness and disease. But it was not until 1897 that the foundation of our modern art of endeavoring to cure the sick with appropriate diet was established upon a scientific basis. E. von Leyden with the collaboration of the foremost men of medical science of Europe gave to the world the epoch-making "*Handbuch der Ernährungs-Therapie.*"

The history of the science of dieto-therapy as related to the acute fevers, or that part of the science of medicine which deals with the application of diet to the cure of acute diseases accompanied by fever, reads like a romance. The medicine of Hippocrates contained much that claims our admiration. But in the subject of diet his directions are irrational, indeed harmful. It was his practice to give his fever patients ptisane, a decoction of barley water and honey. As a beverage it might suffice, but as nourishment it falls far short of the real requirement.

The teachings of the ancient Grecians continued to be the accepted practice in the middle ages. Boerhave and Van Swieten nourished the fever patient with mucilaginous soups and lemonade. The end of the 18th and the beginning of the 19th centuries marks the climax of starvation treatment in fevers. Brown, Broussais and Bouillard were then the great masters in medicine. It may perhaps be questioned whether all practitioners of that time rigidly adhered to the recommendations as given in the literature of those days by these great leaders. Otherwise one would be obliged to believe that not only many fever patients suffered untold agonies for want of food, but that many were sacrificed by reason, not of the fever but of inanition.

To the Irish clinician Graves, belongs the honor of first introducing and recommending a generous diet for the nourishment of the acute fever patient. This he did in his clinical lectures in 1843 in which he boldly declared that the chief source of danger in the febrile patient lay in the inanition, which is to be combatted alone by generous feeding. His declarations were in the nature of genuine reformation. That he had the right conception of the meaning of his endeavors is evidenced by the fact that he said, "If you should be in doubt as to an epitaph to be placed upon my grave, take this, 'He fed fevers.'" His teachings were generally accepted in his own country. Not so in other countries, especially in Germany. About the same time in France, Chossat and a little later Trousseau, called attention to the influence of diet in the cure of acute fevers. In Germany, the genuine Hippocratic dietetic principle reigned supreme until about 1878 (30 years ago).

In 1878 Von Buss, assistant at Immermann's Clinic in Basel,

advocated that easily absorbable nourishment must be given. His practical results were remarkable. But it was not until 1882 (25 years ago) that Hosslin placed the true cornerstone of a solid scientific foundation under the science of dieto-therapy as applied to fevers. He demonstrated, by most thorough and carefully conducted scientific experiments that equally as large quantities of mild food are digested and absorbed in the sick as in the well. He showed that the amounts of nitrogen and fats found in the feces of the sick are only immaterially larger than in the feces of the well, to whom equal amounts of food were given. He also demonstrated that the temperature of the patient is not raised by the giving of nourishment. To Hosslin all credit must be given for the modern accepted principles and practice of feeding in fevers. Since his scientific demonstrations it has become the accepted doctrine the fever patient must not be exposed to the dangers of inanition.

How does a fever patient differ from a well person? What is to be understood with the term fever? These are questions that we will not stop to answer or explain. The subject has been a matter of investigation for nearly 2,000 years and yet, there is no uniformity of opinion as to which forms of temperature elevations to include and which to exclude. But, for the sake of discussing this topic,, the following definition is ventured. Fever is that totality of symptoms produced by bacterial toxins in the body. Elevation of temperature, due to bacterial toxins upon the heat regulating mechanism, is the most prominent symptom, which simple observation reveals. But, we must not identify as one and the same thing the elevated temperatures and the fever. The significance and the seriousness of a sickness depends only in part on the height of the temperature and dieto-therapy must reckon with other symptoms more than with this. In the first place, because it so often determines the prognosis, is the condition of the heart and vascular system. The heart and blood vessels are involved in the pathological processes directly, and at once, on account of the circulating toxins accelerating the pulse, softening of the arterial walls, weakening of the heart muscles, toxically irritating the renal vessels, productive of mild and passing albuminuria of a congestion, to severe and permanent nephritis. These must be reckoned with, as of the greatest moment, in making up the therapy indications—dietetic or otherwise. So also are the additional vital fever disturbances which are to be observed in the central nervous system, ranging from mild sensorial depression, through delirium to coma. These are the reactions of the cerebrum to the fever toxins. The digestive apparatus also must be considered. Here

the fever toxines affecting the glandular parenchyma, lessens the secretion of the digestive juices, hence: scanty saliva, (dry mouth) and diminished gastric juice (weakened digestion) loss of appetite even to revulsion toward all food. And finally the altered condition of the metabolism of the body must be duly considered as a part of the fever ensemble and have its due weight of thought in the nutrition, namely, the increased destruction of the body proteins, and, but in a lesser degree, the increased destruction of the non-nitrogenous substances.

**Classification of diseases having Fever.**—The complexity of the recited symptoms, whose totality are necessary to describe the term "Fever", makes it plain why it is so difficult to arrange the diseases attended with fever, into groups or orders to which general dietetic rules may be suited. Ordinarily all diseases attended with fever are divided into mild and severe. For our purpose we would gladly accept this division. We would then demand that the severer the disease the more emphatic and firm the rules for diet be applied. It must be reiterated here that the height of temperature elevation as a factor of the fever is not alone to be considered in determining the severity of the fever. The body temperature is to be coordinated with the functions of the lungs, of the heart, and the kidneys; the general state of the body, the state or stage of the illness, the condition of the lips, teeth and tongue. Whether there is mild or severe fever, whether therefore the dietetic rules are to be applied rigorously or not, depends in every case upon the closest observation of all fever symptoms and their relative importance toward one another.

It will not to do sum up certain diseases as mild and others as severe. Measles, mumps and angina are generally simple and mild, and as such, need no careful dietary regulations; and yet there may occur a case of measles or angina with such violent symptoms, that nothing is to be neglected in the most painstaking application of every dietary therapeutic regulation. On the other hand there are a number of disease whose anatomic diagnosis never reveal the intensity of the fever symptoms and never indicate the strenuousness with which the dietetic regulations are to be carried out. To this class belong erysipelas, pneumonia, scarlet fever, etc. Pneumonia may present, for instance, in spite of the high temperature such unimportant total fever phenomena, that qualitative dietary restrictions are not indicated; other cases of pneumonia have such an intense fever picture that absolutely the most scrupulous care must be exercised in matters of diet. Finally, it is to be noted, that those febrile diseases which are generally very serious, such

as typhus, meningitis, and sepsis, occasionally may present such mild symptoms as to not require the greatest care in diet which the majority of those class of cases demand.

**A. In Support of the Aetiological Therapy.**—A direct effect upon the bacteria or their toxins can not be accomplished by diet; however, a liberal partaking of liquids will serve as a diluent of the poisons circulating in the blood and thereby assist in their elimination through the kidneys and skin. A flushing of the body should be aimed at. This is not as easily done as said. Von Leyden says that in fever there is a retention of water in the cells of the body. Herz, an eminent investigator and author, supports this imbibition theory of Von Leyden and gives it as the apparent cause of fever. At least the restricted peripheral circulation and the extreme inability to perspire, so very characteristic, would strongly suggest this. The kidney functions are seriously affected thence the increased elimination of water by the lungs and by insensible perspiration. And for the same reason, the relation between the amount of liquid taken, and the total urine eliminated, is generally unfavorable toward the latter.

We are enabled to increase the diuresis by the liberal supply of beverages. Nourishing liquids are better than simply water. The diaphoretic treatment of fever is to be carried out with caution, because by applying warmth to the already inadequately heat radiating body, we may increase the destructiveness of the fever. However, some conditions are determined empirically, in which artificial perspiration is very beneficial to the fever patient. Far more essential is the increase of the diuresis by drinking which we regard as a direct support of the aetiological therapeutics.

**B. Dietotherapy, a part of the Antipyresis.**—When old medicine permitted the patient to starve, it did it chiefly on antipyretic grounds. It was feared that by the taking of nourishment the heat production would be increased. We know better today. We know that the temperature elevation in the fever patient is to only a very insignificant degree due to heat production. The lessening of heat elimination is the cause of hyperthermia. Indeed a well person may eat ever so much and yet there arises but a very slight and temporary temperature elevation, and this increased heat production rapidly passes away. It is therefore indifferent whether the fever patient eats much or little since his heat radiation is very imperfect. Hosslin demonstrated in a number of cases that the temperature in fever is not caused by nor increased by the taking of food.

If no influence on the heat production be caused by the diet,



perhaps in a small way a certain amount of heat abstraction may be accomplished thereby. Artificial heat abstraction as is practiced in hydiatic procedures may be assisted by the temperature of the proffered nourishment: i. e. Liquids that are given the patient should be made as cool as possible. The quantity of heat which is drawn from the body in order to raise 4 liters of liquid nourishment from 6 degrees C. to 39 degrees C., (42.8.F to 102. 2F.) can hardly be considered, in contrast to the immense amount which is retained by the patient; but we are always justified in regarding this as an antipyretic action of the diet.

**C. Diet as part of the Stimulation.**—Among the stimulants for [the nervous system and the heart are coffee, tea and alcohol. No one contends that strong coffee, strong tea and alcohol are not invaluable in collapse states of fever patients. Wine and cognac are regarded by many as excellent articles of diet in most cases of fever. In stimulating the nerves and reinforcing the heart, alcohol is considered by many as a genuine food. The amount of alcohol that is beneficial to the fever patient, is much in dispute. Large doses of alcohol must be shunned, because they paralyze rather than stimulate, they harm rather than do good. How far can the heart be strengthened by nourishment? It is a muscle and acts like other muscles. Underfeeding causes muscles to shrink and leads to weakness. A sufficient caloric quantity of food of the protein constituent saves the muscle substance and support's the heart's power. But for work the heart muscle needs non-nitrogenous matter—glycogen. This glycogen we know can be formed as well out of proteins as out of carbohydrates, and which in a certain sense may be designated as a heart tonic. Indeed recently it has been repeatedly shown that solution of sugar are particularly fitted to support the heart's activity and that it is superior to every other means, to rapidly increase the lowered heart power of the exhausted one. By virtue of these observations we are justified in recommending in the therapeutics of dietetic stimulation and to regard as valuable for fever patients, the carbohydrates and especially solutions of sugar.

**D. Dietic influence on Kidney Function.**—In severe fevers the parenchyma of the kidney is nearly always affected; mild or severe albuminuria, often genuine nephritis is caused by the elimination of the toxins circulating in the blood. Diet may prove very helpful in this condition. Abundant supply of liquids (which increases the diuresis) will serve to dilute the poison which passes through the kidney and in that way help to render it less harmful. All those dietetic experiences which have been

found useful in kidney diseases are to be considered. It is to be remembered not to feed too large quantities of albuminous (protein) food, in order, not to overburden the renal function which is already severely taxed by the elimination of the poisons; and for the same reasons if possible the following are to be avoided because of their irritating properties on the kidney parenchyma—condiments and spices, excess of salt and the organic bases found in meat extract.

**E. The Formation of the Diet with regard to the Digestive apparatus.**—By reason of the Fever, the mouth cavity, the stomach and intestine receive peculiar injury, to which the nutrition must be suited.

**Mouth Cavity**—The saliva gradually disappears in fever; the mouth becomes dry, tongue and lips fissured and coated with scabs. Chewing thus becomes difficult and in severe fevers intolerably painful. It is not well therefore to offer to the fever patient coarse food or even finely divided solid food. However there are now and then some fever patients who have no difficulty in chewing. A higher temperature alone generally does not hinder. But here also the general intoxication is the guiding principle. If we do not give to severe fever patients any solid food it is because we take into consideration the benumbed sensorium, for he who is unconscious cannot, does not, chew. It is best in these cases always to give only foods in solution or at least impalpably finely powdered food in watery suspension. The dryness of the mouth often causes great thirst, the allaying of which is often one of the real problems of the treatment.

On account of the lack of saliva the saccharization of the starchy foods is difficult if not impossible. It is altogether uncertain how far we may trust to the function of the pancreas in converting the starchy foods into sugar; indeed it is quite likely that the abdominal salivary gland is equally incapacitated and therefore one would have to depend entirely upon the intestinal bacteria for the saccharization. Therefore in severe fevers, if it is at all possible, no starchy foods should be ordered. Boiled flour broths or gruels and oven toast soaked or dissolved may be given, because the starches have been converted into soluble dextrine by the long continued high temperature necessary in the preparation of them. The starch molecules must be unlocked and converted before they are allowable. Milk and sugar solutions are the very best foods.

Frequent drinking of liquids and the most painstaking cleani-

ness of the oral cavity are the requirements that are to be arrived at from the consideration of the conditions of the mouth. What nature of liquids is not to be considered at this moment, but it must be given so often and so much as is necessary to keep the mouth clean and moist as in a well person.

STOMACH:—In taking up the particular indications of dietetics, which are to be deduced from the state of the stomach in fevers, it is to be noted first that there is nearly always an entire absence of appetite. While this is in part due to the modified activity of the fever stomach, yet it must be understood that the anorexia is due largely to the depression of the central nervous system caused by the fever toxins (a temporary paralysis of the appetite center). To the physicians of old the appetite stood as a sort of a watchman of health; its failure was a sure sign of the harmfulness of feeding. Today we think differently and especially in fevers; feeding must not be neglected simply because of want of appetite.

Aside from therapy and antipyresis, there grows upon us the duty to arouse the appetite in a purely symptomatic manner. Much is to be accomplished in the selection of foods. Refreshing and delightful foods are to be selected and particular attention is to be given to the mode of preparation and the manner of serving.

Generally the less the appetite, the more is the thirst. It is noteworthy and often observed that in spite of the thirst the patient is often too apathetic to take or to ask for drink, but he drinks greedily whatever is given. Very cold drinks are relished most.

Considering the stomach, we find that the motor functions are decidedly lessened in severe fevers. Little attention has been given to this fact in former considerations of this subject. Yet it is very plain without further explanation how much the entire digestion suffers from insufficient mobility of the stomach. The largest part of the food is absorbed in the intestine. The assimilation of the food and the general well being of mankind depends not a little upon the rapidity with which the chyme is transferred in to the bowel. For, if the foods are retained too long in the stomach, abnormal decompositions, gaseous and soluble fermentations compounds and putrescent products result. The consequences are varied dyspeptic complaints, vomiting and diarrhoea, and sometimes evidences of general intoxication.

Indeed a diminished motor function of the stomach can be observed in many cases of fever. Examination of the vomit furnishes in many cases conclusive proofs. Considerable quantities of lactic acids have been found in the vomit (patients having

previously partaken of oatmeal gruels) a recognized proof of stagnation of the contents of the stomach.

We must learn from this that only small quantities of food should be given to the patient at any one time. Large quantities of foods or liquids demand naturally enlarged motor functions of the stomach. The failure of this function renders intense decomposition liable. We must not on that account fail to give adequate nourishment. The smaller the feeding the oftener it may be repeated.

As a consequence of the ready decomposing nature of food in the relaxed stomach it must be our endeavor to avoid the addition of bacteria in the food i. e. sterile food should be given. It is in point to mention here again the value of frequently repeated mouth cleansing. But above all is to be emphasized the necessity of boiling all liquid nourishment before it is eaten. Of course we have learned in recent times that there are coupled with aseptic feeding also some drawbacks. The denaturizing the protein molecules, which takes place in the sterilization of milk to the detriment of its digestibility, takes place only after long boiling.

The disturbances of health occasioned thereby make their appearance only after many months of its use as food. Nevertheless we desire it to be understood that all liquids before they are given to the fever patient must have been sterilized by boiling.

The secretory functions of the gastric mucous membrane are likewise lowered during fever. A lack of HCL in the stomach contents has often been demonstrated. A subacidity can be shown in very many cases of fever.

Are there special indications for diet in fever patients on account of the sub-acidity?

For a time it was thought best to predigest all protein foods before feeding them and in this way dispense with the HCL in the stomach. Buss gave only peptones and later he changed to albumoses. Since then it has been clearly demonstrated that proteins (not predigested) taken in solution or in powder are assimilated as readily as those artificially digested. This is even true in sub-acid stomachs. In such instances the vicarious action of the intestines for the stomach is shown. The vile taste of the peptone preparations and their tendency to irritate the intestine if given in large doses would operate against their use instead of the undigested albuminoids.

The diminished secretion of the HCL is a new point in support of the general principle, that the food of the fever patient should be absolutely sterile. HCL is a bactericide. On account of its absence



or scantiness the bacteria are enabled unhindered to multiply. Heretofore the less bacteria eaten with the food, the better for the patient.

**THE INTESTINE.**—Nothing of certainty is known about the histology nor of the secretory and motor functions of the intestine of the fever patient. In the post-mortems of those who have died of acute infections, the epithelium of the villi has undergone cloudy swelling, often fatty degeneration has taken place. From this it is to be inferred that the secretion of the succus entericus as is also the gastric juice, is greatly diminished. Clinical observation of the fever patient teaches that the muscles of the intestines lack the normal tonus. Often, indeed, complete paralysis may supervene. Nevertheless, no doubt can be entertained that in spite of meteorism and diarrhoea, the absorption of the intestinal canal of the fever patient departs but very little from the normal. This was first pointed out by Hosslin and has been repeatedly verified. Von L. and K.'s observations on many cases of high fever have been that from 89-94 % of fresh easily digested fats are absorbed and that not more than 9 % albuminoids failed to be absorbed. The carbohydrates have been found in the feces of the fever patient only when unnaturally large quantities (especially sugars) had been eaten, or when the patient suffered from profuse diarrhoea. We would conclude from these observations, that in a general way, the condition of the intestines appears to exert little or no influence upon the nutrition of the fever patient. Sluggish peristalsis with chronic constipation often occurs in fever, mostly because of the continued recumbency. An influence for nutrition is not generally exerted thereby. It would be necessary to have an opening of the bowel before such be accomplished. Diarrhoeas under certain circumstances may be caused by the fever toxins, but in the main they are due to the local disturbances in the small intestines. If the diarrhoeas are profuse then the absorption is decidedly poor. They demand most careful treatment.

**F. Diet Influencing the Metabolism.**—Thus far we have considered only the externals in matters of diet, the intrinsic we touched only in passing.

Now we must answer the following questions:

1. How much nourishment shall be given to a fever patient in 24 hours?
2. In what proportions (after having established the quantity) shall the nutritive constituents be given?

A well person, we know, who works moderately, needs in 24

hours about 3,000 calories and these are best proportioned into the following nutritive constituents:

Proteins.....	100 grams .....	410 Calories.
Carbohydrates.....	400 grams .....	1640 Calories.
Fats.....	100 grams .....	930 Calories.
Total.....		2980 Calories.

But before we prescribe quality and quantity of nourishment for a sick person, we must know whether his metabolism really corresponds with that of a well person or whether on account of the sickness, his metabolism has been altered. If the metabolism is altered by reason of the disease then the nutrition is to be adapted to the altered metabolism. In this way only can a real "Dietotherapy" be developed when success is achieved in combatting disease by prescribing the proper diet. Is there a special modification of metabolism due to fever and in what does it consist?

Even ancient medicine perceived that there was a change peculiar to fever in the metabolism. The heat of fever appeared to the ancient as an expression of increased oxidation, increased destruction of tissue, which naturally led to emaciation. In order not to increase the fire, by the introduction of fresh fuel, they believed that feeding should be restricted as much as possible. Modern investigation also, has placed emaciation as the central point of the symptoms of fever, that one of the real problems of the treatment of fevers is the counteracting of this body consumption.

What is the cause of emaciation in fever? Partially, indeed, because not enough nutriment is given. He who suffers hunger or who does not receive enough food, becomes emaciated. But primarily it must be remembered that the loss of body weight is decidedly greater in fever than in starvation. Fever patients are often observed greatly emaciated who have apparently received no small amount of nutriment. There must be some other factor besides starvation that causes the breaking down of the tissues in the fever patient.

In order to understand this subject of tissue disintegration it is necessary to investigate the subject a little more thoroughly.

In fever, nitrogen elimination is greatly increased. Since first pointed out by Traube-Jochmann, this fact has received many new confirmations. It is well a established truth. These numerous observations have also, at the same time, established the fact that the quantity of nitrogen elimination is amply independent of the nutrition and that it varies in intensity in various febrile diseases. We are in a position today to definitely affirm

first, that the increased elimination of nitrogen is only partially dependent upon the scant nutrition. Secondly, that there is a breaking down of the body proteins, which is specific for febrile diseases; and that it agrees with the modern accepted conceptions when we assume, that a direct effect of the fever toxin causes the tissue cells to break down and thus increases the quantity of the circulating proteins.

The increased elimination of  $\text{CO}_2$  is relatively much less. Naturally the increased destruction of the protein substances will manifest itself in the elimination of  $\text{CO}_2$  and under circumstances cause an increase of the same. The increased labor of the muscles of the heart and respiratory apparatus, lead to an increased consumption of non-nitrogenous substances. Finally the involuntary muscular jerkings of the febrile patient must be regarded as increasing the  $\text{CO}_2$  elimination.

Yet in spite of all these factors, the height of the  $\text{CO}_2$  elimination is not very great. At any rate there is nothing specific to the febrile process in the relation of the fat and glycogen metabolism or at least only so much as leads to an increased muscular activity in the fever process.

From this we are justified in arriving at the conclusion that the total metabolism of the febrile state is but slightly increased—that this increase may be given as from 10 to 20 %. Since nourishment is for the express purpose of replenishing the broken down tissues, according to these considerations, it would be estimated that the total caloric requirements would be placed at 3300. If we would take as a comparison a well—not working person, in bed, whose caloric requirements ought not to exceed 2400 calories, it would cause us to reduce the febrile persons requirement to 2500-2700 calories. This same result is arrived at also, if we calculate the energy requirement from the metabolism (the N and  $\text{CO}_2$  elimination).

If it is possible, in spite of the above mentioned difficulties, namely:

1. Kidney Function Altered.
  - a. Not too large amounts of protein foods.
  - b. Meat extracts.
  - c. Excess of salt.
2. The Altered Mouth Condition.
  - a. Chew, inability to.
  - b. Insalivation, inability to, from lack of saliva.
  - c. Pancreatic juice also lessened.
  - d. Appetite, lack of.

### 3. The Altered Stomach.

#### a. Impaired mobility, causing decomposition.

Large meals require large motor functions.

#### b. Impaired secretory function.

to feed the fever patient the total desired quantity of about 2500 to 2700 calories, there will obviously be enough nutriment to avoid starvation and to supply the demands of the over-exerted muscles, without tissue destruction. But the question arises here: Will the increased caloric supply be adequate to influence the tissue destruction? Can the nitrogen elimination be reduced to normal by the nutrition? As far as it concerns the nitrogen elimination in starvation, it can be answered in the affirmative. But as far as it refers to the toxic effect of the fever, it can not be maintained that the increase of the amount of nourishment can arrest the effect of the toxins upon the protoplasm. According to our idea the toxins of the fever break up the proteins of the cells and tissues, causing them to float in the circulation, where it becomes oxidized into urea and  $\text{CO}_2$ . If the cells, in spite of the fever intoxication, possessed the capacity to absorb albumen, they would not need to wait for the albumens of the food, for they could assimilate the albumens set free by the fever toxine. But since this manifestly does not happen, we are, therefore, to conclude that the protoplasm of the cells intoxicated by the fever (as long as it is under the influence of this poison), has lost the function for assimilating the albumins. These theoretical considerations lead to the following conclusions: The fever patient should receive a liberal supply of food. Thereby the burning up of non-nitrogenous substances of the body will be prevented and at the same time provision will be made that the cells will retain that albuminous tissue, which would be destroyed if not enough non-nitrogenous food were given. Abundant supply of nourishment will limit the fever consumption, but that it will completely cover the loss or even make an increase over and above the loss, diet in acute fevers, will never be able to accomplish, be it ever so generous.

### DISCUSSION.

Dr. O. P. DAVIS, of Topeka:—What I would first say would be in the way of appreciation of this thoughtful and scientific consideration of the subject. I think our profession has been somewhat too negligent of the scientific study of dietetics, particularly of the phase of dietetics which has to deal with the sick individual. Diet tables have been worked out pretty scientifically for the feeding of soldiers, but the medical profession has approached the subject in its bearings upon the sick with a rather vague and uncertain manner. The question of quantity has been considered rather than the question of food value. We have cherished many a fallacy along these lines, some of them have been alluded to, and others might still yet be alluded to. The main thought that impressed itself upon me as being the most practical one was the sentence that the fever patient must not be exposed to the dangers



of enervation. He has enough to contend with from within without being in danger from deprivation from without. In feeding the patient the main considerations have been mentioned by the author of the paper. He has given us very exhaustively the ideas and plans that should be kept in mind when we are feeding the patient, but these may be concentrated and boiled down into a statement like this; That sufficient proteid must be given to protect the patient from protein loss, and sufficient heat value to conserve the body fats. If we could do this the goal would be reached, but we have to contend with forces that are not always easily recognized. We can in a certain way compute the nitrogen loss and possibly we can form some idea of the CO<sub>2</sub> loss, and with these as a basis we can form our diet plans, keeping in mind the number of calories that are required for the patient. A fasting patient or a patient who is not laboring, we must try to make up a diet table that will furnish at least that much heat value and force value. We have been inclined too much to respect milk as the chief basis for diet in feeding fevers. We have been content in the past if we could get our patient to take two quarts of milk a day, we have congratulated ourselves we were feeding him nicely, but when we stop to think two quarts of milk only represent something like 1200 calories we can see we are very inadequately supplying the needs of the patient; even if he were not sick he would be getting far from the required amount of food.

Dr. M. F. SUDLER, of Lawrence:—In regard to the cellular pathology of fever the doctor has very well brought out. I heard a recent lecture by Dr. Chitman with reference to nutrition, and it struck me as having some bearing on this point. He laughed at our old ideas whereby the proteids were supposed to be broken down and resulting in a similar chemical compound, and he said our old ideas were that certain forms went through the digestive tract and were absorbed; his investigations seemed to show that the compounds were very much more simple than had been formerly thought and that these simple compounds were picked up probably and reconstructed in some way in the blood, and when they get to the individual cell it had its own ferments, so that the proteids which formed that particular cell were specified for that particular cell, whether it was one in the brain or in the liver, that they were all different and that they possessed each one its own chemical, laboratory to manufacture its own food, so when we come back to this question of feeding, we have to consider just that point, and it seems to me Dr. Minnenger brought it out in his paper, that these cells do act queerly, do not act like normal cells, and this little observation fits in with that point of view.

Dr. H. B. CAFFEY, of Pittsburg—This subject is certainly a very interesting one, one which we general practitioners are more or less interested in. I have enjoyed the paper very much, and the discussion, but I don't believe that the fever patient requires the amount of food or the number of calories for his sustenance that a man in perfect health would require. I believe that we are up against the proposition of sustaining the system which is being attacked by disease but in a way which will not overtax the digestive powers. We know that fever is a pathological process resulting from the failure of the nerve centers to control tissue repair and tissue integrity, through which the transformation of energy into tissue building force ceases, and transformation into heat ensues, and during which through the same nerves' failure the tissue or blood becomes subject to combustion, so that if we can sustain our fever patients so as to counterbalance the tissue's destruction, and add to his powers of construction, and at the same time giving him the proper sustenance to his digestive organs, we will accomplish in my opinion, the greatest amount of good. There is no question but that fever patients, even in judicious feeding, can be easily overfed.

(No closing discussion.)

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Psychology in medicine or suggestive therapeutics is mental materia medica, and the physician who fails to use it treats only one-half of his patient.

## SCREW WORM DISEASE—(MYIASIS.)

ZACHARIAH NASON, M. D.,

AND

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In the Journal of the American Medical Association for December 7, 1907, Doctors Yount and Sudler report twenty-three cases of human myiasis (*compsomyia macellaria*—Fab.) occurring in Arizona.

In the Kansas City Medical Index for December, 1897, Dr. Hal. Foster reports a case in which he found 207 screw worms, and refers to two other cases where only three and five worms were found. In all, the chloroform was the effective remedy.

In Bulletin No. 5, of the U. S. Department of Agriculture, a very good account of the screw worm is given by Dr. Herbert Osborn, Professor of Zoology in the Iowa Agricultural College. In this account due credit is given to our Professors Williston and Snow for their notes on the disease, published in the early 80's.

Recently several cases have been found in and about Kansas City of which we had the good fortune to see one. We present the case history herewith in order to call the attention of the physicians of Kansas to what we believe to be a rather frequent (and if unrecognized, fatal) infection during the warm seasons of the year. Another case came to post mortem and showed very little beyond the perforation of the bones and the irritation of the mucosa. We feel the more justified in presenting this report because most of the cases of which we have learned were unrecognized until very late in the course of the disease.

**Case History**—Dr. Z. Nason's report.—Arthur B., 825 Coy St., Kansas City, Kansas.—On September 19, a blow-fly got into his right nares. On September 25th he noticed a tingling in his nose and frequent sneezing. On September 26th he reports that he noticed a sense of fullness in his throat, and he thought he had some fever, rapid pulse, loss of appetite, and some headache. On September 27th the symptoms were very much worse—chills, higher fever, with pain in throat and head. On September 29th I was called at nine o'clock in the morning. I found temperature 101; pulse, 108; respiration irregular; great difficulty in swallowing, accompanied with much pain-; marked constipation; total loss of appetite. On examining the throat, I found the back part of mouth and throat much swollen, oedematous, some odor. On ex-

aming his pillow I found blood stains. I was called again the next day, and found temperature  $102\frac{1}{2}$ ; pulse, 120; breathing and swallowing difficult; swelling decidedly marked on right side of throat and mouth. It had all the appearance of an abscess; and indeed the symptoms were that of quinsy which I thought it to be at that time. When I called on October 1st, I found that the abscess had broken during the night. He said there was a marked elimination of pus; temperature  $99\frac{1}{2}$ ; pulse, 98; breathing normal; swelling and redness much less. In fact, he had improved in every particular. After this visit he began to bleed freely from the nose. I was recalled. While packing his nose to relieve the hemorrhage, patient spat up a large clot containing 21 maggots. Bleeding stopped. Patient comfortable. On October 2, 3, 4, and 5, patient rapidly grew better. On the 5th, I sent him to Eleanor Taylor Bell Memorial Hospital for examination and report.

The treatment in the early part of the case was simply calomel in broken doses, saline laxative, astringent gargle, with hydrogen peroxide. Strychnin was also given to sustain the heart, and phenacetin  $2\frac{1}{2}$  grains, at 3 hour intervals, for the fever. When the screw worms were discovered, I injected a 50 per cent oil solution of chloroform into the throat and nose twice daily.

*Hospital Notes.*—The patient entered the Eleanor Taylor Bell Memorial Hospital on October 5, at 2:00 P. M. His temperature was 98.4; pulse, 70; respiration, 19. On examination, spots lighter and more yellow than the somewhat inflamed mucous membrane were disclosed on the right side of the palate and on the right pillars of the fauces. Two of these spots were also near the middle line close to the junction of the soft and hard palates. When probed, these spots proved to be necrotic but empty. The right nostril was edematous, and yielded on cleansing considerably bloody mucus. The right submental region was swollen and there was a feeling of lumps underneath the skin. The uvula was edematous; the right eustachian tube was widely open, and because of the patient's sense of something in the ear, this was probed, and irrigated, but nothing found therein. The blood analysis gave the following result:

Hemoglobin, . . . . .	70. %
Red cells, . . . . .	4,320,000. %
White cells, . . . . .	5,600. %
Polymorphonuclear neutrophiles, .	52.5 %
Large lymphocytes, . . . . .	33. %
Transitional cells, . . . . .	4.5 %
Eosinophiles, . . . . .	2.5 %
Basket cells, . . . . .	1.5 %
Degenerate cell forms, . . . . .	5. %

Considerable variation in the size and staining quality of the red cells was noticed by Dr. Trimble who made the examination.

The patient was treated by irrigation with hydrogen peroxide and the local application of an oil solution of chloroform.

The next day the patient felt much better; and when the examination showed that the nostril and throat were in a more nearly normal condition than the day before, he was allowed to go home, with instructions to report to Dr. Nason.

The patient reported to Dr. Nason on Oct. 7, 8, and 10, and outside of some soreness in the throat and right ear, the recovery seemed to be complete.

### DISCUSSION.

*Incubation*—Inasmuch as the eggs hatch within a few hours, and the larvae require a week for developing into the adult fly, the incubation period might be spoken of as one week. In our case it should be noted that the first symptoms appeared on the 25th; while the blow fly invaded the nostril on the 19th.

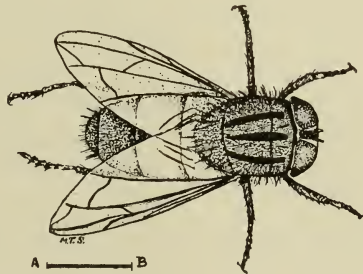


Fig. 1.—The adult screw worm fly (*Comptosia macellaria*—Fab.) magnified 3.5 diameters. The line A B is the actual length of the fly.—(Sudler.)

*Pathological Anatomy*—In a recent fatal case in Kansas City the post mortem examination developed nothing more than reddened and eroded cavities throughout the ethmoidal and frontal bones. In other words, there seemed to be nothing except the evidence of the local habitation of the worms. In our case there was the evidence of beginning necrosis of the palate. In the fatal cases reported by Osborn, we find the following notes:

“Azara was, I believe, the first observer who noted cases of human myiasis in South America. Coquerel, many years later, called the attention of physicians and naturalists to the frequent and fatal accidents which this evil produces among the exiles of Cayenne. According to this author, Dr. Chapuis, physician in chief of the French marine, attended one case in which the larvae of *C. macellaria* had penetrated the frontal sinuses, causing the



death of the patient; also one very unclean person attacked in the nasal fossae and the pharynx, who succumbed after he had ejected one hundred and twenty larvae. There were, as M. St. Pair observed, in the same country six similar cases of which three terminated in the death of the patients after cruel sufferings; in two the nose was destroyed, and in the last there was a deformation of the olfactory organ. In another case observed by M. St Pair there were removed by means of injections, more than three hundred larvae, but he was not able to obtain them all, and the remainder soon penetrated the ball of the eye, destroying the lower eyelid in consequence of gangrene, invaded the mouth, corroded the gums, and laid bare the inferior maxillary. The victim died seventeen days after his entrance into the hospital."—Williston, translation from Arribalzaga.

"Upon a very minute and careful examination after death I was astonished to find that all the tissue covering the cervical vertebrae, as far down as I could see by throwing the head back and compressing the tongue, was wholly destroyed and the vertebrae exposed. The palatine bones broke with the slightest pressure of the finger. The os hyoides was destroyed and the nasal bones loose, only held in position by the superficial fascia."—Britton.

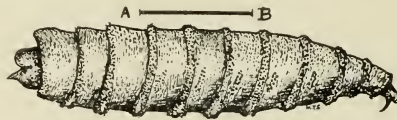


Fig. 2.—Larva of the screw worm fly (*Comptosia macellaria*—Fab.) magnified 3.5 diameters. The line A B is the actual length of the maggot. —(Sudler.)

*Symptomatology*—The symptoms are those of the presence of pus, the pain being severe on account of the great tension. When the over-lying membrane breaks the discharge is of a sanguineous type.

*Mortality*—Dr. Sudler reports the mortality in the cases which he collected from literature and from the practice of Dr. Yount at 15 per cent; that of the nasal cases alone being 22 per cent.

*Diagnosis*—The diagnosis can be made only by stimulating the maggots to show themselves; and for this purpose chloroform seems to have been the best application. Aside from the finding of the maggots there seem to be no symptoms that are pathognomonic. But suspicion of the presence of the screw worm is justified in cases where the symptoms of nasal or tonsillar abscess—or even of diphtheria—are accompanied by blood stains on the pillow.

*Treatment*—The treatment must be the removal of the maggots, and as noted above, these appear only when stimulated by the application of chloroform. This should be applied, diluted with olive oil, on a swab as well as with a spray. In addition to the use of chloroform, the free application of hydrogen peroxide has proven very helpful. This should be used in full strength of

the commercial solution and put in with a syringe. Its mechanical action also will tend to expel the worms.

We are indebted to the Journal of the American Medical Association for the cuts which illustrate this article.

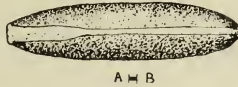


Fig. 3.—Egg of the screw worm fly (*Comptosmia macellaria*—Fab.) magnified 30 diameters. The line A B is the actual length of the egg.—(Sudler.)

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## THE OPPORTUNITY AND DUTY OF THE KANSAS MEDICAL SOCIETY.

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By W. H. GRAVES, M. D. Wichita, Kans.

Read before the Kansas Medical Society at Iola, May 7, 1908.

This is a paper with a prelude. That I may not be open to the charge of sordidness in dealing with the subject, I beg that what I have to say as to the financial side of the practice of medicine be interpreted in accordance with the spirit of these halting lines:

### LABOR DULCIS.

“—who went about doing good”—Acts 10:38.

Oh, Thou, who once didst walk the earth with healing in Thy touch,  
And bring sweet rest to weary frame, and peace to anxious mind:  
Grant me, Oh Lord, this gracious boon: In service to my kind  
To live my life, secure from lure's vale and penury's clutch;  
The welcome treasure Thou has given, the crown of fruitful years,  
To lay upon the yearning breast of blessed motherhood;  
Pain to relieve and life to save; to smoothe the rugged road  
Of him whose tale of life is told, whose journey's end appears;  
To cherish childhood, soothe its griefs, and all its ills assuage;  
To win from error's devious ways the feet of ardent youth;  
To armor manhood with the stainless panoply of truth;  
To guard the faltering steps, and cheer the heart of fainting age.  
Be this my joyful labor; this my pledge of brotherhood:  
My high ambition—fellowship with Thee in doing good.

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That a man should approach mature life with a high purpose to do worthily a man's work in the world, to be of signal service to his fellows, to deserve and enjoy their esteem, is altogether credita-

ble to human ambition. Nowhere is this noble desire oftener found than in the medical profession.

That, as life advances, his hopes should fail, the visions of his youth grow dim, and his ambitions die in a sea of disappointment and apathy too deep for plummet to sound, is anything but creditable to human intelligence. And in no profession is this infinitely sad ending so common as in the profession of medicine.

Sixty-two years ago in New York came together the first delegate body of physicians for the purpose of forming the American Medical Association. A young man had a vision of the good that could be accomplished for and by his beloved profession by organized and concerted action; and in 1846 the American Medical Association was born for the purpose of securing the adoption by all the medical schools in the United States of a requirement of a suitable preliminary education, a uniform and elevated standard of requirements for the degree of M. D., for the government of the entire medical profession by the same code of ethics, the establishment in each state of a single board of medical examiners, the enactment in each state of suitable laws for the registration of births, marriages and deaths, and the adoption of a nomenclature of diseases.

This young man had a vision of a profession, every member of which should be a man of trained intellect before beginning the study of medicine, and who should before entering upon the practice of the healing art, give ample evidence of systematic and thorough knowledge of medicine to a board entirely independent of any influences or motives other than that of carefully ascertaining the fitness of the applicant for the responsibilities of the physician.

Four years ago we laid to rest the body of this erstwhile youth, grown venerable, and universally venerated. His life was unparalleled among American physicians for fruitful industry; and his just fame as a great physician and scientist is only surpassed and in a measure obscured by his greater fame as the organizer of the medical profession into a body of scientific men actuated by a love of knowledge and cultivating to the highest degree the ability to use that knowledge in the alleviation of the sufferings of their fellows.

It is not often given to men to see, in their old age, such rich fruition of the hopes of their youths as Nathan Smith Davis enjoyed. Dr. Davis saw the fulfillment of the purposes for which the Association was formed, except as to the provision for the registration of births, marriages and deaths. Progress in that field is slow. But in the field of medical instruction the actual accomplishments of the past sixty two years have surpassed the brightest dreams of the great founder. This is no time to compare the magnificence of the

present with the meagerness of the past, language would fail of adequate comparison, and the achievements of recent years are familiar to you all. And this equipment great as it is, is but a promise of that which is to come. For medicine has not arrived at the zenith of its glory. There are still some obstacles to be overcome.

There is no profession that so appeals to the eye, the imagination, the love of one's kind, as the medical. None begins to compare with it in the value of the material with which it has to do, the closeness of touch with the highest and best in human kind; none so exacting in the requirements of devotion and self-abnegation when engaged in the performance of its functions, and the readiness of its followers to face danger at the call of distress. No other profession to-day requires such an expenditure of money, and energy for the acquirement of reasonable ability to perform its duties; and in no other profession are shown higher ideals of duty and service to humanity. On the other hand, in no other profession is there exhibited so great negligence of the requisite means for carrying these ideals into effect, and making the visions of youth the realities of later life.

The scientific side of medicine has been developed far out of proportion to the business side. We have been so anxious to relieve suffering and save life that we have given comparatively little attention to the subject of compensation for our services. We freely care for the poor in hospitals and for some who are not poor. We treat without price uncounted thousands at public dispensaries. We are so anxious to do good and accumulate a large list of patients that we are easy marks for the rounder, and gladly welcome him to our office when our colleague across the street has driven him away by his belated demands for compensation. We feel honored by being elected physician to a club organized for the purpose of getting medical services for less than cost; and have an overwhelming sense of our dignity when we have been initiated into the order of the mystic pass in return for personal services to a job lot of railway employees. We scrap with each other for the honor of being county physician at half the salary paid the county attorney, though the lawyer does far less work and has not a tithe of the responsibility. We devote time and skill in making insurance examinations for a dollar when our juridical brother would get from five to ten times the amount for a like expenditure of energy. We are so devoted to raising the standard of medicine and so afraid of the contamination of politics that we permit osteopaths and christian scientists and fakers of all kinds to enter into our field of usefulness and compete with us on equal terms to the



detriment of the public whose guardians we are in matters relating to their health, instead of using the power that we have with the public and compelling these gentry to submit to the same tests which we rightfully require of legitimate medical men.

The financial problem is of prime importance; for while there can be no improvement without the vision, without the desire to improve, neither can there be improvement without the means to put that desire into execution. Thus we are face to face with a business condition which has a direct bearing on the scientific side of medicine. For it is clear that if the physician can not in the long run obtain an adequate compensation for his services, the character of the services must deteriorate.

The public esteem the profession of medicine highly. Sometimes I think that this esteem partakes of the nature of a superstition; for they are often just as deferential to a pretentious man of mediocre attainments as to a man of great learning and ability; but the esteem of the profession is a fact. While many are afflicted with the erroneous idea that there is an occult something that in a mysterious way prepares the doctor for the practice of medicine, and while many are lured into the advertising faker's net, and while many are drawn into a fatuous faith in various pathies by the loud claims of their practitioners and exploiters; under and through all this blundering is a faith in the medical profession and a belief in its scientific ability and I have never yet found a disinterested man who does not readily acknowledge the propriety of requiring the same tests of ability on the part of all who undertake the practice of the healing art, whether they are physicians or those who call themselves by some other name to cover their advance into the field of medicine.

In addition to the advancement in medical education and in the education of the Public to a proper appreciation of the value of scientific medicine, which will soon be undertaken on a large scale by the American Medical Association, we need more efficient regulations of the practice of medicine. And here lies the opportunity and duty of the Kansas Medical Society.

It is a false modesty that would shun this task. It is our duty and the cry of personal profit that is hurled at us by the incompetents who have tried with greater or less success to take a short cut to the practice of medicine, ought not to deter us from its performance; should not have any more effect than when made against the faithful sentinel who warns the camp of the approach of the foe. And it is a dishonor and a disgrace for him to remain silent under such circumstances, so ought it to be a dishonor and a disgrace for

us to fail in our care for the public health. And as the faithful soldier is honored by the beneficiaries of his devotion, so shall we receive the reward of high esteem and deserved honor if we faithfully perform this duty.

The State Medical Society must undertake the reformation, and assist in the enforcement, of the medical laws of the State. There is no reason to fear that our proffer of assistance will be rejected by the authorities. On the contrary, there is every reason to expect that it will meet with a cordial reception.

It is the obvious duty of the Kansas Medical Society to place at the service of the State its scientific skill and professional knowledge in assisting the authorities, and especially the legislative authorities, to conserve the health of the citizens. And as a rational movement to that end, I suggest the appointment of a committee who shall have authority to employ competent legal assistance in framing a bill for the more efficient regulation of the practice of medicine to be presented to the legislature at the approaching regular session. I suggest also that the committee be composed of men who have an active interest in the subject, and whose residences are such that they can meet occasionally without great expense of money and time. It is far better that the committee be selected from a single city than from cities so widely separated that they can not get together often enough to accomplish anything.

One of the first changes that such a committee would probably make would be to impose on the Governor the duty of consulting the Kansas Medical Society or the Faculty of the Medical Department of the State University in selecting men for the boards of medical registration and examination, and of public health. We should then be free from reproach, as to one of these boards, of having a set of officers to administer the law who have no interest in its operation beyond their fees. And incidently we should not have to bear the reproach of withdrawal of reciprocity by other states because of a too previous distribution of examination questions.

In such a plan as this the Society would have an executive officer who would devote his whole time to its interests and be compensated accordingly. He would be Secretary, editor of the Journal and general organizer. He would keep in touch with the county societies all over the State, and his occasional visits, with the counsel and assistance which his broad experience would enable him to give, would be valuable. In this way he would do part of the work now done by the Councillor and greatly relieve that overburdened and self sacrificing officer. With his aid the county societies would

work more efficiently in the enforcement of the law and as an active officer he would be a valued assistant to the committee on legislation.

He would study the various problems that effect the financial side of the physician's life, as for example the contract practice problem, above referred to, and gather together data touching this important and heretofore detrimental factor in the practice of medicine.

With these agencies effective, the A. M. A. in the role of educator of the public to a better appreciation of the practice of medicine, and continuing the magnificent work it has inaugurated, in the critical examination of the teaching of the medical colleges on the one hand, and of therapeutic agents on the other; with the State Board working harmoniously with the Association and the State Society in carrying out the provisions of well digested State laws and counselling actively and efficiently with the legislature as to what those laws should be; and with the county societies putting into motion the machinery of those laws against unlicensed and criminal practitioners, the practice of medicine in the State of Kansas will soon rise to a higher place in the public esteem, and scientific physicians will far more nearly than now realize their early dreams of efficient service to their fellows with the emoluments, material and honorary, which that service should bring.

#### DISCUSSION.

Dr. E. J. LUTZ, of Kansas City, Kansas:—I have listened with great pleasure to the paper of Dr. Graves. The opportunities and duties of the Kansas Medical Society are great. He speaks very well, we devote too much time to the scientific part and not enough to the business part. Not very long ago I had the pleasure to find on the streets an open letter from an osteopathic society, and the top of it read "Self Preservation is the First Law of Nature". I read the letter, and it stated that there would be a meeting of the osteopaths of that city to discuss rules and regulations, and so forth, and bills to present in the next legislature. I knew who the different osteopaths were of the city, I knew who their stenographer was, and got next to him, and that so-called scientific meeting was nothing else but a business meeting, what to do with the legislature, when to get next to it, not when they meet in Topeka, but to get next to them when they run for office. We have so little time, the business portion is done by 25 or 30 members you must sometimes pardon my speaking of matters we know,—probably a great many of us don't know those things. The American Medical Association is busy, they have organized in the last two or three months and directed each committee from the state to name one man in each county to act as auxiliary men to that committee, and inform them of what is needed. The tuberculosis question, that is up, and then some amendments that are necessary in regard to Board of Health, to give them more power, all those opportunities and duties that the Kansas Medical Society has, and it is our duty to get busy beforehand, not afterwards. I was instructed by the American Medical Association to procure an active physician in each county, to get the name and correspond with him, and after the details are given to me by the society here and the A. M. A. to notify them what we need in the next legislature so we can go before the legislature and demand these things because our constituents demand them. I believe if we act



along that line and organize and get busy and do those things beforehand. like the politician does, he gets busy and says "I will do so and so for you if you will do so and so for me," you have got to tie them down, unless you do that you will not succeed. We have got to use politics a little in that. We have got to be smooth and make it the order of business as physicians.

Dr. J. F. GSELL, of Wichita—It strikes me Dr. Graves made a suggestion in his paper that is a good one, and one that is well for us to consider as The Kansas Medical Society. The doctor suggests in his paper the advisability of electing a secretary for the State Society and selecting someone who can give his entire time to that work, and the duties for the secretary such as outlined in his paper, one of his duties being to deal with the legislation. Too often the work of a committee or several committees, the work is not accomplished. Very often one man would be able to accomplish things a number of men would not accomplish, and I think that thought is one we can well take into consideration, and might at least in the next few years, adopt.

Dr. HOPKINS—I notice an allusion to the examination questions from the State Board of Registration of Kansas, and withdrawal of reciprocity of Missouri, and I think inasmuch as our state board to a certain extent is supposed to represent the State Society in its official actions, it would be well if Dr. Light who is on the floor would tell us something about that examination and show us the Board is not so much at fault as the allusion would lead us to believe.

Dr. G. C. GLYNN, of Iola—It seems to me the way to influence the legislature or any other man is to produce the facts where the men can see them, give them the evidence, and the way to produce the facts is to find out what the facts are, and the best way in the world to find out the facts in this state or any other state is to commence with the city. The plan that could be suggested that would do more good than any other is to let each city in this organization stand for a uniform accounting system, that way the business man will see the advantage of them; and the State of Ohio in the course of 18 months saved the citizens of that state two million dollars. That appeals to them. In addition to that, the statistics can be put up to them, and you can start in on the counsel and you can go to the legislature and say: "Here are the facts." "It is an economic proposition to save lives," and in that way you can get to the legislature. You can say: "Gentlemen, we are in position to tell the facts." We have lowered the death rate in Iola just on that plan, and it is a business proposition. We can show you where we have removed the filth and we can show you where the people are breathing free from the effects of it, and if you can put it into this condition and put in a uniform accounting system, you can get the support of every municipality in the State of Kansas, and when they get up there and see we have delivered the goods at home, they will come through.

Dr. GRAVES, :—(Closing the discussion.) I am very sorry not to hear from the State Board. What I saw was in the public print, and it wasn't all I heard of the unfortunate dissemination of the examination questions. I was told authoritatively by a medical student that wasn't the first time that had occurred. I am not blaming the Missouri State Board,—I don't want to be understood as casting any reflection on them. As regards the practical working of the plans I have suggested, I don't claim any originality. It was first suggested to me last summer by Dr. Simmons. What is every man's business is no man's business. That was the object of the paper and was all I intended to impress on the Society.

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Simplicity in dosage marks the intelligent and safe internest.

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Mixed or complex dosage is an abomination to the apothecary, is liable to be an incongruity in chemistry, and questions the diagnosis of the physician.



# THE JOURNAL

## OF THE

# Kansas Medical Society.

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**JAMES W. MAY,** - - - - **EDITOR.**

**J. E. SAWTELL,** { ASSOCIATE EDITORS } **CHAS. S. HUFFMAN.**

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Subscription Rates: \$2.00 per year, 20c single copy. Advertising rates furnished promptly on application.

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The Journal was established in June, 1901, by a publication committee at Topeka. In May, 1903, Dr. G. H. Hoxie was elected editor and served four years. In January, 1904, it incorporated the Wichita Medical Journal, owned by Drs. W. H. Graves and G. K. Purvis, and the Western Medical Journal, owned by Dr. A. J. Roberts, of Ft. Scott. In March, 1908, it incorporated the Wyandotte County Medical Journal, owned by Dr. James W. May. It is now printed in Kansas City, Kansas, and appears the first of every month. Correspondence should be addressed to the editor. Editorial office, 501-2 Husted Bldg., Kansas City, Kans.

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**OFFICERS OF THE SOCIETY.**—C. C. Goddard, Leavenworth, President; E. E. Liggett, Oswego, 1st Vice-President; G. W. Goss, Sedan, 2nd Vice-President; B. M. Barnett, Rosedale, 3rd Vice-President; Charles S. Huffman, Columbus, Secretary, L. H. Munn, Topeka, Treasurer.

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## EDITORIAL

The "pen is mightier than the sword," so the saying goes, although there are few indeed who would not rather risk a duel with the former than the latter.

—o—

County Secretaries are urged to send in reports of the meetings held in their districts, and also items of medical interest. This Journal is for the physicians of Kansas first, last and always and should be used by them. Stimulate your meetings by publishing accounts of them in the Journal, and let outsiders know you are alive.

—o—

Dr. S. C. Emley recently called attention to the use or rather mis-use of the terms tubercular and tuberculous. He says at this time the former is used so many places when referring to a disease caused by the tubercle bacillus. It would be better to confine the word tuberculous to those diseases caused by the tubercle bacillus and let tubercular be used when we mean a lumpy or nodular lesion which may be either tuberculous or syphilitic. In other words, it would be better to use tuberculous when we mean disease caused by the tubercle bacillus because tubercular has reference to shape

rather than origin and may be either a tuberculous or a syphilitic lesion. You will notice the best writers make this distinction.

The doctor's point is well taken and the above correction should be adhered to.

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Time and progress does most certainly change the methods of prescribing and dispensing of drugs. The old idea of incorporating in a prescription a drug for every symptom manifest, and some that were not manifest, is obsolete. Mono-therapy bids fair to assume its just position and hereafter in place of prescribing for every symptom, one drug will be given for the whole chain of symptoms. It is obvious how much will be gained by this procedure, for when there is improvement in the patient it will be known to which drug belongs the credit and vice versa.

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The idea was recently advanced by someone that a great many of us make the mistake of an incomplete diagnosis. For instance, that having examined a patient presenting symptoms of a certain ailment, the examination is stopped and the patient put upon treatment without going further to find the co-existence of other diseases. This is a fault that a great many supposedly thorough physicians are guilty of, and it simply emphasizes the fact that we must go over our patients with great care using every appliance, old and new, that will give us an insight into the true condition.

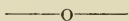
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The authorities in Kansas City, Mo., are making strenuous efforts to rid the city of druggists who have been selling cocaine and morphine without physician's prescriptions. The Police Judge has imposed the maximum fine upon their conviction in his court, with the result, that several druggists have quit business entirely and the other guilty ones have about given up the practice. This practice, which has been going on for years, and years unmolested is one of the worst offenses that a druggist can commit, for it is plainly a traffic in human souls. It is to be hoped that the crusade will be a permanent one.

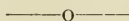
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At this day and age it is an absolute necessity for the successful physician and surgeon to carry a policy for protection from alleged malpractice suits. It seems that when physicians, or, for that matter, any successful business man gets into the well-to-do column there is always some grafter or shyster lawyer ready to try and get a portion of his wealth. It is a notable fact that a very

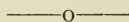
small per cent of the suits brought for malpractice are successful. One reason for this is the fact that in a very few cases are there any grounds for suit and another is, that many of the doctors have availed themselves of the protective policy, the company agreeing to fight the cases to the last ditch.



Kansas can be depended upon to do her share toward the prevention of tuberculosis. At the time of going to press Governor Hoch has issued a call for a conference of all who are interested in the campaign for the study and prevention of tuberculosis, the meeting to be held at Topeka, Dec. 3, 4 P. M., at Representative Hall. That this meeting promises much in the educational propaganda to work as a Kansas branch of the national association goes without saying. Everyone, in and out of the medical profession should be interested enough, if not able to attend the meeting, to join the association by paying one dollar for membership.



"Our name in public print" has never been the subject of any great deliberation by medical men, and it seems that many of the so-called reformers are either "chair warmers" or secretly glad to have their names adorn the pages of the public press. The ethical medical men--and our profession is composed overwhelmingly of this class--do not desire to elevate themselves in this manner and, consequently, knowing themselves as they do, hesitate to point the finger of accusation at their neighbors, therefore the guilty are let alone. This practice, which is certainly nauseous in the extreme perhaps can be corrected by having the secretary of the county society take all of the items concerning physicians and patients from the daily press and read them in open society. Perhaps after being embarrassed a few times in this manner, a greater delicacy might be engendered as to newspaper advertising.



The medical profession is aroused to a sense of duty and of its importance and influence as it never has been in the history of medicine. Preventive medicine is its shiboleth--and preventive medicine is the medicine of the present largely and will be more so in the future.

The medical man is becoming broader in his conception of duty because he knows more and he prizes life more highly and realizes his responsibility to his fellow man more acutely because of this increased intellectual and moral point of view being more clearly defined and accepted.

To cure people when they get sick is laudable, but to prevent

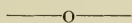
them from getting sick is best. In order to keep people from getting sick their environment must be known, and if not conducive to health must be changed, modified, bettered and made sanitary. There is too much vicarious thinking done as yet. Thinking one's own thoughts is hard work and the mass of mankind is willing to let others think for them. It is the duty of the physician to educate his people in the laws of hygiene in their persons, homes and in what to eat and drink.

J. E. M

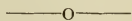


## CLINICAL NOTES

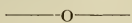
Dietetics is of the first importance in the treatment of the sick.



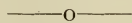
The minimum dose should be the rule in prescribing and the maximum dose the exception.



The specialist in medicine must ever be on his guard or his medical horizon will become microscopic.



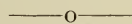
The old idea that there is danger of salivation when giving calomel and lemonade simultaneously is erroneous. Calomel is acted upon very slowly by non-oxidizing acids and therefore not injurious when given with lemonade.



**Pruritus Senilis.**—Levy remarks in the *Berliner klinische Wochenschrift*, September 28, 1908, that Leo, Kohler, and Stroll state in the *Therapeutisches Jahrbuch*, that it is possible to relieve, and very often cure, pruritus senilis by the following:

R̄	Diluted sulphuric acid,	5.0 grammes;
	Distilled water,	175.0 grammes;
	Syrup of rubus,	30.0 grammes.

M. S. One tablespoonful every two hours.



The following simple and efficient test for formaldehyde in milk (from *Ohio State Medical Journal*, Nov., 1908) may be found very useful when that drug is suspected: Introduce a little of the suspected milk into a test tube. Add an equal bulk of water and then allow a little strong sulphuric acid (containing a trace of ferric chloride) to run down the inside of the tube. Allow to stand a few minutes. If formalin be present a beautiful violet ring forms at the junction of the strong sulphuric acid and the diluted milk. In the absence of formalin a greenish yellow tinge is observed. The reaction if positive should occur within two minutes. The acid used in the



above test may be conveniently prepared by adding a small crystal of ferric chloride to ordinary strong oil of vitrol. The acid must be poured in a slow stream down the inside of the test tube. Delicacy of test, 1 part of **formalin** in **200,000** parts of milk.

—o—

Cystic tumors of the breast differ from tumors of this kind in other regions, in that fluctuation is usually absent. In fact, they may give a sense of distinct hardness, so as to simulate a cancer or sarcoma. Under these circumstances it is advisable in doubtful cases to aspirate, as recommended by Abbe, of New York, using a small sharp needle.—International Journal of Surgery.

—o—

**Application for Orchitis.**—The following ointment is recommended to be rubbed into the skin (Journal de medecine de Paris, October 24, 1908):

R	Synthetic guaiacol,.....	3iiss;
	Methyl salicylate,.....	3iv;
	Lard,.....	3iii.

N. Y. Medical Journal.

—o—

**The Treatment of Chronic Gastritis.**—Kahane recommends equal parts of compound tincture of cinchona and tincture of orange peel, fifteen to twenty drops of which are to be taken twice daily before eating, or the following:

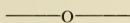
R	Tincture of nux vomica,.....	℥ lxxv;
	Tincture of orange peel,.....	3iv.

M. et Sig: Fifteen to twenty drops twice daily before meals.—N. Y. Med. Journal.

—o—

**X-Ray Dangers and Abuses.**—W. S. Gottheil, New York (Journal A. M. A., November 21), thinks that the optimistic tide has turned as regards radiotherapy in dermatology, and that we do not now hear so much of its wonderful results. Experience is also teaching us that while it may be of therapeutic use, it is also capable of doing great and even irreparable damage. Without venturing to criticise its use for other purposes, he believes that in dermatology while it has a positive value in certain conditions, this utility is a limited one, and two conditions, in his opinion, must be present to justify its use. In the first place the affection must not be a trivial one; there must be sufficient reason, either from the gravity of the disease or on account of its effect on the patient, to warrant the use of a remedy of uncertain and possibly deleterious effect. In the second place the disease must be one that is not amenable to the

ordinary accepted and safe modes of treatment. When employed it should be with caution, as its dosage is unmeasurable, the individual reaction unknowable in any given case and its results uncertain. It should also be used only by skilled operators, familiar with its dangers, and whose experience and known skill are guarantees that all needed precautions are taken. He gives a list of diseases in which he thinks it should not be used, including eczema, psoriasis, acne, alopecia areata, alopecia prematura, pruritus hypertrichosis, folliculitis, verruca, ordinary ringworm, favus, etc., for all of which we possess other efficacious remedies. In lupus erthematosus it is conceded to be useless. He would also exclude epithelioma and rodent ulcer, except in cases unsuited for caustics, curetting or the knife. The x-ray may be used in lupus vulgaris, though it is not the only method of cure in many cases, and scrofuloderma and very extensive ringworm of the head and beard, on account of the tediousness of other treatment in such cases. It is the method of choice in epithelioma and rodent ulcer, so situated that other treatment cannot be employed or so extensive that other methods are hopeless, and in relapses after other methods; in tuberculosis cutis, erythema induratum and some other tuberculides; in sarcoma, mycosis fungoides, rhinoscleroma, keloid, and acne keloid, in which diseases Gottheil knows of no other remedy that has given as good results.

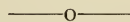


**Treatment of Acute Laryngitis.**—Mendel advises repose in bed in a room guarded from noise, with the inhalation three times a day, morning, noon and night, for three to five minutes at a time, of the following solution contained in a suitable atomizer:

R	Balsam of Peru,.....	gr. viiss;
	Tincture of benzoin,	
	Tincture of eucalyptus,.....	aa 3i;
	Tincture of soap bark,.....	℥ lxxv;
	Cherry laurel water,.....	3iiss;
	Distilled water,.....	3xiiss.

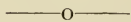
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The patient should be cautioned not to use the solution too freely at first, as it may prove irritating. If the parts are very sensitive and the solution causes irritation its use should be stopped.—N. Y. Medical Journal.

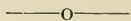


The internest or general practitioner is the coming man in the medical profession.

Preventive medicine is now the shiboleth of the medical profession.



The advance of medicine marks the progress of civilization.

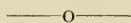


**Tuberculin Tests.**—Mary C. Lincoln, Chicago (Journal A. M. A., Nov. 21), describes and compares the value of the von Pirquet skin test and the Calmette conjunctival tuberculin test in the diagnosis of tuberculosis. Besides describing her own methods and results, she gives her views of the work of others in this line. Her results are tabulated and she specially calls attention to certain facts, viz: (1) The tests do not agree in every case: 80 per cent of the cases that gave positive results to both the cutaneous and the ocular tests were verified by the opsonic index. The von Pirquet and conjunctival tests agreed in 92 per cent, of the non-tuberculous, in 69 per cent of the cases of bone and joint tuberculosis, and in 64 per cent. of the cases of pulmonary tuberculosis. (2) In spite of the disparity of the results of the tests on the same cases, the percentage of positive results is nearly the same in all. (3) As might be expected theoretically, the more advanced the disease and the lower the reacting power, the smaller the per centage of positive results. (4) A study of the tuberculo-opsonic indices shows that there is a larger per centage in cases of advanced disease and a larger percentage of low indices in cases of less advanced disease. (5) Considerable variation was found from the normal tuberculo-opsonic index in the non-tuberculous cases on account of the generally lowered resistance of some of these cases, though clinically non-tuberculous. It had been previously found that the normal tuberculo-opsonic index ranges from 0.8 to 1.2, as determined by examination of over 100 healthy individuals. There are no published results of harm coming from the use of the von Pirquet test but this is not true of the conjunctival test, which should be used with caution. It is certainly contraindicated in existing inflammatory diseases of the eye.



## NEWS NOTES

Dr. John Outland, formerly of Topeka, has established his residence in Kansas City, Kansas.



Dr. O. S. Hubbard has been appointed assistant superintendent for the Parsons State Hospital for Epileptics, vice Dr. Skoog, resigned. Dr. H. P. Mahan has been appointed first assistant physician.

Dr. Chas. S. Huffman, of Columbus, Kansas, was re-elected State Senator on the republican ticket at the election held in November.

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Dr. M. L. Perry, of Parsons, Kansas, was elected Vice-President of the Medical Association of the Southwest at the recent meeting held in Kansas City, Mo.

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The Wilson County Medical Society met at Neodesha, Tuesday night, Oct. 13th. Sixteen members were present. Papers by Drs. McGuire, Rogers and Moorehead were read and discussed. Meeting adjourned to meet at Benedict, in December. Refreshments were served by the physicians of Neodesha.

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The Labette County Medical Society held its regular monthly meeting Wednesday, the 25th, at the Matthewson hotel. Several very interesting clinical cases were reported. Dr. Geo. Liggett, of Oswego, read a paper on Post-graduate Courses of Study for Medical Societies." This paper, with the outlines furnished by the A. M. A., elicited considerable discussion and a committee was appointed to consider the advisability of adopting this course. Dr. Petty, of Altamont, presented a paper on typhoid, which was well presented and brought out considerable discussion.

O. S. HUBBARD, Secy.

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The Third Biennial Report of the Parsons State Hospital for Epileptics has just been issued by Dr. M. L. Perry, the Superintendent. The report is complete in every particular and shows the improvements made in the past two years and points out the needed ones. In his medical report his records show that during the past two years 50 per cent. of the patients received in which an error in the diagnosis was made and of the 183 patients admitted 5.4 per cent. were found to be not epileptic. In the causes given for epilepsy heredity is given the first rank. He deplores the fact that the laws to prevent the marriage of epileptics and imbeciles is not enforced, and should be amended by requiring a more thorough inquiry into the physical condition of parties applying for marriage license, with a penalty for failure to make such investigation.

—o—

The Johnson County Medical Society met with the Secretary, at Gardner, Monday evening, October 12, 1908. We had a liberal attendance and all present seemed to enjoy the program. Dr. O. C. Thomas, of Springhill, read a paper and related a case of



hysteria. Dr. H. E. Williamson, of Olathe, read a paper on gonorrhea. It was excellent and to the point. Both papers were fully discussed. The Society admitted to membership Dr. R. E. Eagan, of Springhill, and Dr. M. F. Sloan, of Stillwell. We adjourned to meet at Springhill, on the 2nd Monday evening in November. The Society met with Dr. O. C. Thomas, Vice-President, Monday evening, November 9th, 1908, at Springhill, Kansas, with an excellent attendance. The papers of the evening: "Acute Parenchymatous Nephritis," by Dr. R. E. Eagan, Springhill. An excellent production, well discussed. "The Prevention of Disease" by Dr. F. F. Greene, Olathe, Kansas. Dr. O. T. Leftwich, of Gardner, Kansas, was admitted to membership. Our Society was never in a more healthy condition. The interest seemed to be lagging, but the plan of meeting in the various towns of the county has revived us and added strength to our numbers. We recommend the plan.

W. C. HARKEY, Secretary,

—o—

The Wyandotte County Medical Society met in joint session with the Jackson County society Nov. 24th, in Kansas City, Mo. Fully one hundred doctors were present and a very instructive and interesting meeting was the result. It was strictly a clinical meeting.

Drs. Fryer and Lichtenberg, of Kansas City, Missouri, exhibited a two year old child the subject of "amaurotic family idiocy of Sachs." Its chief interest was the scarcity of the disease, less than one hundred cases being in print. Drs. Neff and Kimberlin, who had studied the case previously, insisted that a question mark be placed after the diagnosis as three of the chief signs were missing: The cherry red spot of the retina, the absence of other cases in the family, and the absence of murasmus. Dr. Hanawalt admitted the diagnosis might be correct, but that the case should be placed in the larger class of infantile palsies, the eye symptoms being merely an addition to those more commonly found. In closing, Dr. Fryer said the murasmus was developing rapidly and there were no other cases in the family as the parents were young and this was the only child.

Dr. Weaver showed a case of congenital coloboma of the iris in a child and illustrated its development by drawings of embryology.

Drs. Barney and Gray demonstrated an immense pyonephros specimen which they had removed recently. Its chief interest was the size and the fact that there were two ureters. Dr. Mark had made two ureteral catheterizations but had never found a super-

fluous opening in the bladder. The diseased kidney passed more fluid than the sound one, but he insisted it was pathological fluid and not normal excretion. Dr. Cordier's opinion was that these cases should be drained and the kidney left to do what work it would, saying that such a vital organ should not be recklessly removed. Dr. Gray met this argument by saying that the usual result of nephrotomy was a long standing, possibly permanent, sinus, and that his experiences would prompt him to do nephrectomy in nearly all cases and especially the case under discussion. The kidney was opened later and showed multiple abscesses, no stones, and probably pyogenic (non-tubercular) in character. The specimen when intact was as large as a three pint vessel.

Dr. Froehling exhibited two cases of great interest medically: One a women past forty with a diagnosis of aneurysm of the ascending aorta, which had been treated by Dr. Hamilton, of Cincinnati, with nineteen feet of wire alloy and a so-called cure effected. Some doubt was expressed by many present as to the exactness of the diagnosis as the tumor was too low down and too far to the right for aneurysm of the ascending part of the aorta. The other case was that of an elderly woman recently dropsical, now presenting a greatly hypertrophied heart, enlarged liver, arterio sclerosis and very rapid pulse. The doctor's diagnosis was aortic insufficiency, but with no murmurs. He explained it as shrinkage of the semilunar valves and dilatation of the aorta by the sclerosis present. He was criticized for exhibiting the case and findings outlined with no chance for others to examine. He readily offered the case for examination, which was done by several present. No one ventured to dispute his findings.

These union meetings of the two societies are to be frequent hereafter and will prove interesting to the doctors on both sides of the Kaw.—H. W.

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## **Proceedings of the Third Annual Meeting of the Medical Association of the Southwest at Kansas City, Mo., Oct. 19 to 21, 1908.**

COATES HOUSE, OCTOBER 19TH.

A meeting of the Executive Committee with the following members present: Dr. B. J. Vance, L. H. Buxton, J. Johnson, G. H. Moody, W. H. Cary, Dr. John Punton, Chairman of the Committee of Arrangements; President Thomas E. Holland, and F. H. Clark.

The Secretary presented the application of Dr. J. Reed Lytle, of Kansas, who was not a member of the State Association because his County Association was not affiliated with the State Association, but who asked membership in the Medical Association of the Southwest. Application was rejected and the Secretary instructed to write him that according to the con-

stitution, none but members of the component State Associations in good standing could become members of this Association.

The Secretary reported that he had secured the services of Mr. William Whitford, of Chicago, who is the official reporter for the A. M. A., to report the proceedings of this meeting at a rate of ten dollars per day and twenty cents per folio for two copies of the transcript of the proceedings.

On motion duly seconded and carried the action of the Secretary was endorsed and he was authorized to pay for such service.

On motion of Dr. Punton, duly seconded and carried, the rule was adopted that during this meeting papers should be read alternately from each section.

The Chairman of the Committee then outlined the arrangements made by the Committee for the meeting, including the social features, which included a dinner for the visiting ladies and their husbands; an automobile ride for the physicians as well as for the ladies and a smoker for the men.

The Secretary-Treasurer then presented his report for the year giving a brief synopsis of the effort made to reach and interest all the members of the profession in the five component states. The present membership number 580 which was a very satisfactory gain during the past year.

The financial report shows:

Total receipts during the year,.....	\$653.29
Total disbursements for same time,.....	\$622.35
Balance on hand,.....	\$ 30.94
Total outstanding bills unpaid \$91.25.	

An auditing committee consisting of Drs. E. H. Cary, John Punton and the Secretary were appointed to audit the books and accounts and after reporting that they found the accounts and books correct the report was accepted and ordered spread on the minutes.

A letter from Dr. Herbert L. Burrell, President of the A. M. A., regretting his inability to be present and wishing the Association a very prosperous year and a good meeting, was read and ordered read to the Association at one of the general meetings.

The President addressed the committee at length regarding the necessity for hearty cooperation on the part of the state Journals if we are to make this Association a success and was authorized to appoint a publication committee consisting of one from each state who is a member of the Executive Committee to devise ways and means to accomplish this result.

The meeting then adjourned to meet at 12 M. Tuesday, October 20th.

CASINO HALL, October 19th, 2:00 P. M.

General meeting of the Medical Association of the Southwest called to order by the Chairman of the Committee of Arrangements, Dr. John Punton, of Kansas City, Missouri, who announced that Mayor Thos. T. Crittenden, who was to deliver the address of welcome, was unavoidably detained, and introduced Dr. Jabez Jackson, who, in a few well chosen words, gave a cordial welcome to the visiting physicians and their wives in behalf of the profession, of Missouri and of Kansas City. Dr. Punton then announced that immediately after the adjournment of this session the visiting physicians were invited to become the guests of the physicians of Kansas City and enjoy an automobile ride over the beautiful parks and boulevards. He then introduced the President, Dr. Thomas E. Holland, of Hot Springs, who called upon the following to respond to the words of welcome for their respective states: For Arkansas, Dr. C. T. Drennan, of Hot Springs; for Oklahoma, Dr. A. K. West, of Oklahoma City; for Missouri, Dr. C. W. Fassett, of St. Joseph; for Kansas, Dr. George M. Gray, of Kansas City, Kansas; and for Texas, Dr. Joe Becton, of Greenville.

Meeting then adjourned until 8:00 P. M.

COATES HOUSE, October 19th, 9:00 P. M.

Meeting called to order by Vice-President, S. S. Glasscock, who introduced the President, who then delivered his annual address, which dealt particularly with the birth, origin and need of this Association. Meeting then adjourned to take up the scientific program at 9:00 o'clock A. M., Tuesday morning.



The following were appointed as members of the Nominating Committee:  
 From Kansas—Drs. George M. Gray, C. C. Goddard, Noah Hays, Hugh B. Caffey, and S. S. Glascock.  
 From Missouri—Drs. Mott, Fassett, Lockwood, Dixon, and Stauffer.  
 From Oklahoma—Drs. M. A. Kelso, A. K. West, H. C. Reed, R. V. Smith, and S. M. Jenkins.  
 From Texas—Drs. F. D. Boyd, Joe Becton, E. H. Cary, D. Strickland, and Bacon Saunders.

CASINO HALL, October 20th, 9:00 A. M.

Meeting called to order by Vice-President S. S. Glascock, who introduced Dr. Bacon Saunders, who read the Chairman's address of the Section on Surgery, which was followed by the Chairman of the Section on General Medicine, Dr. F. B. Young, and who was followed by Dr. L. H. Buxton, Chairman of the Section on Eye, Ear, Nose and Throat. Dr. S. S. Glascock then introduced the Hon. T. T. Crittenden, Mayor of Kansas City, who briefly welcomed the visitors to Kansas City, and assured them that owing to the authority granted him by the charter he was in a position to assure the visitors that the city was theirs and that if any of them got into trouble he would only need to produce his credentials showing him to be a member of this Association to secure executive clemency.

Dr. Punton then announced that at 2:00 P. M. the committee to entertain the visiting ladies would take the physicians for an automobile ride around the boulevards, stopping for tea at the country club. Also that the visiting physicians would be entertained with a smoker in the Coates House Tuesday evening at 8:00 P. M.

The Secretary reported that since the meeting of the Association at Hot Springs about 150 new members had applied for admission to the society, all of whom represented themselves to be in good standing as members of their respective state Associations, and asked if he should read the names of these applicants. Upon motion the reading of the names was dispensed with and the Secretary instructed to enroll them as members.

Meeting to take up the work of the scientific program.

COATES HOUSE, PARLOR A—October 26th, 12:00 M.

Meeting of the executive committee called to order by the Chairman, T. E. Holland, with the following members present: C. H. Moody, John Punton, L. H. Buxton, B. J. Vance, Bransford Lewis, C. T. Drennon, LeRoy Long and F. H. Clark.

A free discussion regarding the work of the publication committee was indulged in and the President announced as the committee for the coming year the following:

For Arkansas—Dr. C. T. Drennon.  
 For Missouri—Dr. Bransford Lewis.  
 For Oklahoma—Dr. L. H. Buxton.  
 For Kansas—Dr. Geo. M. Gray.  
 For Texas—Dr. G. H. Moody.

The publication committee were intructed to meet at 5:15 Tuesday afternoon.

Committee then adjourned to meet Tuesday evening at 8:00 o'clock.

COATES HOUSE—October 23th, 8:00 P. M.

Meeting of the executive committee called to order and the Secretary who had been authorized to prepare and present the report of the executive committee then presented the report, which embodied the portions of the report already presented by the Secretary showing the present membership and the financial items, the report showed the effort made to interest all the county officers in the five states and the effort made to secure their attendance at this meeting and recommended that the effort be renewed next years; it also contained the report of the special committee appointed to attend the annual meeting of the A. M. A. at Chicago and ask for recognition as a Branch Association and reported that that had been formally promised by Dr. J. N. McCormick at that time. It also mentioned the need for more thoroughly presenting the aims and needs of this association to the profession at large through the different state journals and recommended that this matter be urged and an active campaign be carried forward in



this department. The question for consideration then was whether the association should next year have general sessions as had been arranged for this year and the recommendation was then made that there be only two general sessions at the next annual meeting with the remaining sessions divided up into sections for scientific work.

After accepting the above report and authorizing the Secretary to present the same at the general session Wednesday morning the Committee adjourned to meet Wednesday after the election of the new officers, at 12 M.

CASINO HALL—October 21st, 9:00 A. M.

Meeting of the Association called to order by President Holland. Dr Geo. M. Gray of Kansas City, Kansas, then presented the following resolution which, upon motion, duly seconded and carried, was unanimously adopted:

"Resolved that the Medical Association of the Southwest approves the efforts of the graduate trained nurse to raise the standard of education and to obtain proper recognition through registration."

(Signed), GEO. M. GRAY.

The report of the executive committee's report as outlined elsewhere was presented, which, upon motion duly seconded and carried, was adopted and ordered spread on the minutes.

The following resolutions were then presented by Dr. E. H. Martin of Hot Springs Arkansas:.

WHEREAS, the tendency of physicians and charitable organizations over the country is even now to send advanced, indigent consumptives from homes to climate resorts, notably parts of Texas, Colorado, and the Southwest; And,

WHEREAS, the consensus of opinion among the best authorities is that climate alone cannot cure tuberculosis; And,

WHEREAS, boarding houses and hotels in many resorts no longer open their doors to this class of people, thereby depriving them of any chance of securing proper accommodations; and,

WHEREAS, the sanitariums and eleemosynary institutions of the South west are already overburdened with such cases and the people are called upon to do double duty in that they must take care of others beside their own consumptives;

Therefore, be it resolved, that all states and territories throughout the country, and all physicians and charitable organizations be urged to discourage the aimless drifting of the average consumptive and that all advanced consumptives be kept within the confines of their own city, county, or state, and that the legislatures of the several states be urged to pass such laws as will insure the building and maintenance of sanitariums for curable cases and hospitals for advanced cases and incurable cases.

(Signed), E. H. MARTIN.

On motion seconded and duly carried the above resolutions were unanimously adopted. The Secretary was also authorized to notify the secretary of each state association of this action.

The report of the nominating committee was then presented, placing in nomination for the office of president for the coming year, Drs. Jabez N. Jackson of Kansas City, Missouri, and S. S. Glascock of Kansas City, Kansas. Upon motion of Dr. Glascock duly seconded and carried the rules were suspended and the Secretary was instructed to cast the unanimous vote of the association for Dr. Jackson for president for the ensuing year. The Secretary then announced that he had cast 243 votes for Dr. Jackson for president and the President declared Dr. Jackson duly elected.

The committee then nominated for vice presidents for the ensuing years, Drs. M. L. Perry, Parsons, Kansas; M. A. Kelso, Enid, Oklahoma; Joe Beeton, Greenville Texas, and St. Cloud Cooper of Fort Smith, Arkansas. Upon motion the rules were suspended and, as before, the Secretary instructed to cast the unanimous ballot for each of the above. The Secretary then announced the ballot and the president declared each elected.

The nominating committee then presented the name of Dr. F. H. Clark of El Reno, Oklahoma, for Secretary-Treasurer for the coming year and upon motion the Secretary of the nominating committee was instructed to cast the unanimous vote of the association for Dr. Clark for Secretary-Treasurer, and the president declared him elected.

Dr. Bacon Saunders then moved that a rising vote of thanks be tendered the Secretary for his services in behalf of the association during the past year, which was unanimously carried. After, the secretary in a few words thanked the Association for the honor they had conferred and pledged his best efforts in the year to come.

The president then appointed as a committee of two to wait upon the president elect and inform him of his election and escort him to the platform, Drs. Bacon Saunders and C. W. Fassett. While Dr. Fassett was searching for the president elect, Dr. Bacon Saunders presented the following resolutions, which were unanimously adopted by a rising vote:

In view of the unbounded hospitality and the ample facilities afforded this association at this meeting for the comfort, pleasure and delectation of its members,

BE IT RESOLVED, that the thanks and sincere appreciation of the Medical Association of the Southwest, be expressed by a rising vote to the profession of Kansas City, to its committee of arrangements, and to all those who have in any way contributed to the royal greeting and lavish hospitality extended to us during this meeting;

And especially do words fail us when we attempt to voice the gratitude of our hearts for the very great courtesy shown in providing such unflinching means for the pleasure and happiness of the visiting ladies. They must be a gentle and hospitable people indeed who care so well for the strangers within their gates.

Here is to the City by the Kaw—may her longevity and prosperity be as boundless as her hospitality.

(Signed) Bacon Saunders.

The president elect, Dr. Jabez N. Jackson, was then installed into office and addressed the association setting forth briefly the aims and ambitions for the coming year and asking for the same loyal support that had been accorded his predecessor.

The following members of the executive committee were then elected to serve for three years:

Dr. B. J. Vance—Checotah, Oklahoma.

Dr. J. D. Riddell—Enterprise, Kansas.

Dr. E. H. Martin,—Hot Springs, Arkansas.

Dr. C. W. Fassett—St. Joseph, Missouri.

Dr. D. Strickland—Cleburne, Texas.

The nominating committee then presented San Antonio, Texas, as the next Place of meeting which was upon motion duly selected and the meeting adjourned to finish the scientific session.

F. H. CLARK, M. D.,  
Secretary-Treasurer.

Section officers for the ensuing year:

Section on Surgery:

Chairman, Dr. J. A. Foltz, Fort Smith, Arkansas.

Vice Chairman, Dr. R. H. Barnes, St. Louis, Missouri.

Section on General Medicine:

Chairman Dr. A. K. West, Oklahoma City, Oklahoma.

Vice Chairman, Dr. G. H. Moody, San Antonio, Texas.

Secretary, Dr. Louis M. Warfield, St. Louis, Missouri.

Section on Eye, Ear, Nose and Throat.

Chairman, Dr. F. D. Boyd, Fort Worth, Texas.

Vice Chairman, Dr. J. E. Gsell, Wichita, Kansas.

Secretary, Dr. A. W. McAlester, Kansas City, Missouri.

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## BOOK REVIEW.

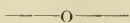
**SURGERY.** By John Allen Wyeth, M. D., LL. D. (University of Alabama ), President of the New York Academy of Medicine. Cloth. Pp. 816. with 864 illustrations, of which 57 are colored. Price, \$6.00. New York: Marion-Sims Wyeth & Co., 1908.

After twenty-one years the profession is so familiar with.

Wyeth's text book on Surgery (published by D. Appleton and Company) that it seems hardly necessary to call attention to his new edition, Wyeth's Surgery, by the Marion-Sims-Wyeth Company.

A comparison of the 1887 work with this last book, demonstrates how much of the surgery of the youth of some of us is now obsolete. It is not like the usual text book on Surgery, it is more useful for the active practitioner than the student. While not exhaustive like some of the composite works of several volumes, it is quite comprehensive, covering the eye, ear, nose and throat diseases, urine and blood. It covers the entire range of general and special surgery. It is a practical guide to the recognition and treatment of the most common and most important major and minor affections.

It should continue to hold the high place that its predecessors, "Wyeth's Text Book on Surgery," has held for the last twenty-one years. —L. H. M.



**CONSUMPTION:**—How to prevent it and how to live with it. Its nature causes, prevention, and the mode of life, climate, exercise, food, and clothing necessary for its cure. By N. S. Davis, A. M., M. D., Professor of Principles and Practice of Medicine, Northwestern University Medical School, Chicago; Physician to Mercy and Wesley Hospitals; Member of the American Medical Association, American Climatological Association, Illinois State Medical Society, Chicago Medical Society, Chicago Pathological Society, Chicago Neurological Society, Chicago Academy of Sciences; Fellow of the American Academy of Medicine; Author of a Hand-book on "diseases of the Lungs, Heart and Kidneys," and a treatise on "Diet in Disease and Health." Second Edition, thoroughly revised. 12mo. 172 Pages. Bound in Extra Cloth. Price, \$1.00, net. F. A. DAVIS Company, Publishers, 1914-16 Cherry Street, Philadelphia, Pa.

The need of educating the public in medicine is now conceded and its importance attested by the general inauguration of lecture courses and the appearance of many magazine articles. Furthermore, in no particular is there greater need of this education than along the lines of tuberculous disorders.

Dr. Davis has made for himself an honorable name in medical literature and is therefore one from whom one expects really important contributions.

The text before us is written so completely from the standpoint of the physician that possibly it will not appear to general readers with great force. But to those who are seeking help, it will be very welcome, because the statements are clear, precise and succinct. It will be especially interesting for doctors themselves to peruse, because it will furnish an excellent and up-to-date summary for our knowledge of the disease.—G. H. H.

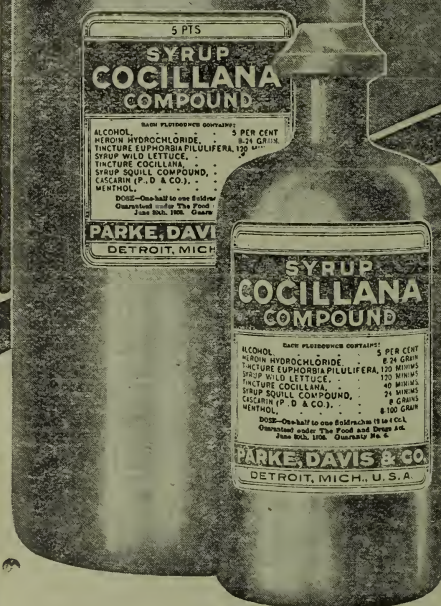
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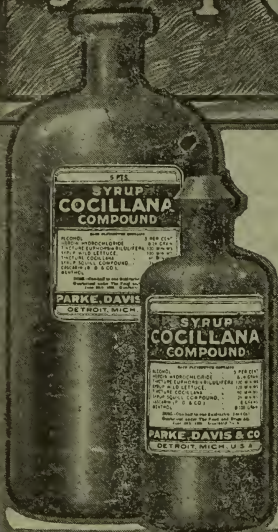
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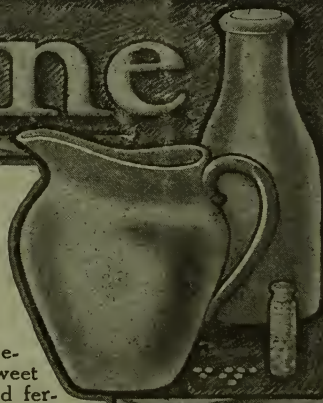
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Much Lower temperature

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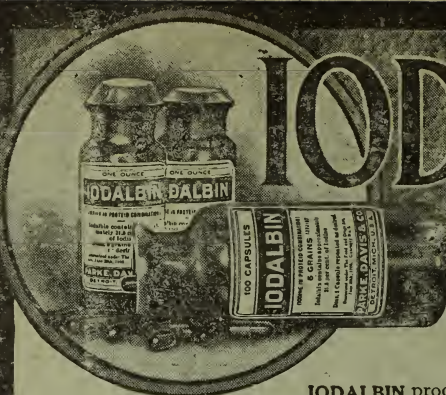
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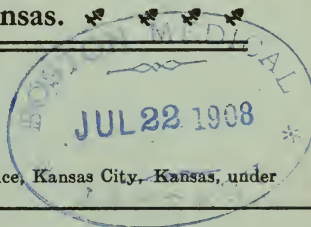
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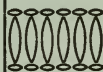


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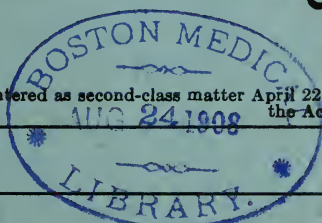
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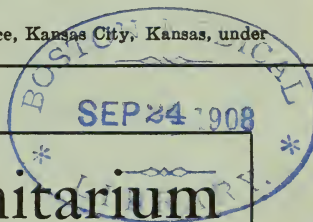
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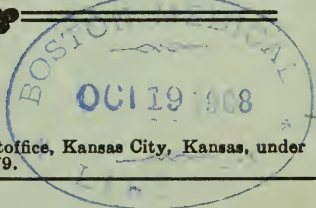
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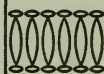


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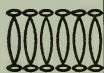
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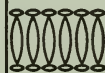
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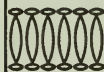
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